Filing at a Glance

Company:	Denver Health Medical Plan, Inc.
Product Name:	Elevate by Denver Health Medical Plan, Inc.
State:	Colorado
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Rate
Date Submitted:	05/13/2013
SERFF Tr Num:	DVHH-129023224
SERFF Status:	Closed-Filed
State Tr Num:	278033
State Status:	Filed
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Laurie Goss
Reviewer(s):	Cathy Gilliland (primary), Nichole Boggess, Michael Muldoon, Amy Filler, Rachel Plummer
Disposition Date:	08/01/2013
Disposition Status:	Filed
Implementation Date:	01/01/2014

State Filing Description:
SERFF Binder Filing: DVHH-CO14-125001113 state code 850-645

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: File & Use
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Laurie Goss

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Non Employer Group - Individual
Filing Status Changed: 08/01/2013
State Status Changed: 08/01/2013
Created By: Laurie Goss
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions: This product will be offered only inside the Exchange

Filing Description:
This is the rate filing for Elevate, the plans Denver Health Medical Plan, Inc. will be offering to individuals on the Connect For Health Colorado website.

Company and Contact

Filing Contact Information

Laurie Goss, Commercial Product Manager
777 Bannock Street
MC 6000
Denver, CO 80204

laurie.goss@dhha.org
303-602-2065 [Phone]
303-602-2094 [FAX]

Filing Company Information

Denver Health Medical Plan, Inc.
777 Bannock Street
Mail Code 6000
Denver, CO 80204
(303) 602-2004 ext. [Phone]

CoCode: 95750
Group Code:
Group Name:
FEIN Number: 84-1354846

State of Domicile: Colorado
Company Type: Health Maintenance Organization
State ID Number: CO

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Please enter state-specific code(s) found in Colorado's Filing Requirements Bulletins, or on the General Instructions page. Please list all applicable state-specific codes. If no codes are applicable, please enter N/A.: 850
All rate and loss cost filing types MUST be submitted with completed Rate Data Fields in accordance with Sections 10-4-401 and 10-16-107 C.R.S. This requirement does not apply to form filing types. Rate and loss cost filings not including this data will be rejected. If this is a rate or loss cost filing, have these fields been completed?: N/A
Have you completed the Forms Schedule Tab? ALL Life, Accident, and Health Rate and Form filing types require the Form Schedule Tab to be completed. In addition, all Form, Annual Form Certification, and Refund Calculation filing types require the Form Schedule Tab to be completed. The actual form must be attached to Form filing types only when filing: Medicare Supplement, Long-Term Care Partnership, Stop Loss, P&C Summary Disclosure Forms, and Workers Compensation. It is not necessary to submit the actual form for other lines of insurance. Thank you.: Yes

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Nichole Boggess	08/01/2013	08/01/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rachel Plummer	06/14/2013	06/14/2013
Pending Industry Response	Cathy Gilliland	06/04/2013	06/04/2013
Pending Industry Response	Cathy Gilliland	05/29/2013	05/29/2013
Pending Industry Response	Cathy Gilliland	05/22/2013	05/22/2013
Pending Industry Response	Cathy Gilliland	05/15/2013	05/15/2013

Response Letters

Responded By	Created On	Date Submitted
Laurie Goss	06/19/2013	06/19/2013
Laurie Goss	06/07/2013	06/07/2013
Laurie Goss	06/03/2013	06/05/2013
Laurie Goss	06/03/2013	06/03/2013
Laurie Goss	05/15/2013	05/15/2013

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/01/2013
Implementation Date: 01/01/2014
Status: Filed

HHS Status: HHS Approved
State Review: Reviewed by Actuary

Comment: State Tracking # 278033
Company: Denver Health Plans
Product Line: Individual HMO

Rate Change Summary
Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing. The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).

On Exchange Only Plans
Gold: 2
Silver: 2

Final Rate Filing Disposition
The Division has filed the rates in their final form after all adjustments.

See attached document for more information on this filing.

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Denver Health Medical Plan, Inc.	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #: *DVHH-129023224* ***State Tracking #:*** *278033* ***Company Tracking #:***

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

Percent Change Approved:
Minimum: 0.000%
Maximum: 0.000%
Weighted Average: 0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	HR-1 Form (H)		Yes
Supporting Document	Consumer Disclosure Form		Yes
Supporting Document (revised)	Actuarial Memorandum and Certifications		Yes
Supporting Document	Actuarial Memorandum and Certifications		Yes
Supporting Document	Unified Rate Review Template		Yes
Supporting Document (revised)	Rate Sample		Yes
Supporting Document	Rate Sample		Yes
Supporting Document	Benefits Ratio Projection		Yes
Supporting Document	PPACA Benefits		Yes
Supporting Document	Actuarial Memorandum PDFs		Yes
Supporting Document	Actuartial Memorandum addendum		Yes
Supporting Document	Objections_6_14		Yes
Form (revised)	DHMP ElevateS Basic EOC (70%)		Yes
Form	DHMP ElevateS Basic EOC (70%)		Yes
Form (revised)	DHMP ElevateS Basic EOC SPANISH		Yes
Form	DHMP ElevateS Basic EOC (73%)		Yes
Form	DHMP ElevateS Basic EOC (87%)		Yes
Form	DHMP ElevateS Basic EOC (94%)		Yes

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	DHMP ElevateS Basic EOC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateS Basic EOC (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateS Basic application (70%)		Yes
Form	DHMP ElevateS Basic application (70%)		Yes
Form	DHMP ElevateS Basic application (73%)		Yes
Form	DHMP ElevateS Basic application (87%)		Yes
Form	DHMP ElevateS Basic application (94%)		Yes
Form	DHMP ElevateS Basic application (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateS Basic application (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateS Basic SBC (70%)		Yes
Form	DHMP ElevateS Basic SBC (70%)		Yes
Form (revised)	DHMP ElevateS Basic SBC SPANISH		Yes
Form	DHMP ElevateS Basic SBC (73%)		Yes
Form	DHMP ElevateS Basic SBC (87%)		Yes
Form	DHMP ElevateS Basic SBC (94%)		Yes
Form	DHMP ElevateS Basic SBC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateS Basic SBC (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateS Expanded EOC (70%)		Yes
Form	DHMP ElevateS Expanded EOC (70%)		Yes
Form (revised)	DHMP ElevateS Expanded EOC SPANISH		Yes

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	DHMP ElevateS Expanded EOC (73%)		Yes
Form	DHMP ElevateS Expanded EOC (87%)		Yes
Form	DHMP ElevateS Expanded EOC (94%)		Yes
Form	DHMP ElevateS Expanded EOC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateS Expanded EOC (Limited Cost Sharing Native American)		Yes
Form (revised)	DHMP ElevateS Expanded application (70%)		Yes
Form	DHMP ElevateS Expanded application (70%)		Yes
Form	DHMP ElevateS Expanded application (73%)		Yes
Form	DHMP ElevateS Expanded application (87%)		Yes
Form	DHMP ElevateS Expanded application (94%)		Yes
Form	DHMP ElevateS Expanded application (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateS Expanded application (Limited Cost Sharing Native American)		Yes
Form (revised)	DHMP ElevateS Expanded SBC (70%)		Yes
Form	DHMP ElevateS Expanded SBC (70%)		Yes
Form (revised)	DHMP ElevateS Expanded SBC SPANISH		Yes
Form	DHMP ElevateS Expanded SBC (73%)		Yes
Form	DHMP ElevateS Expanded SBC (87%)		Yes
Form	DHMP ElevateS Expanded SBC (94%)		Yes
Form	DHMP ElevateS Expanded SBC (Zero Cost Sharing Native American)		Yes

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	DHMP ElevateS Expanded SBC (Limited Cost Sharing Native American)		Yes
Form (revised)	DHMP ElevateG Basic EOC (80%)		Yes
Form	DHMP ElevateG Basic EOC (80%)		Yes
Form (revised)	DHMP ElevateG Basic EOC SPANISH		Yes
Form	DHMP ElevateG Basic EOC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateG Basic EOC (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateG Basic application (80%)		Yes
Form	DHMP ElevateG Basic application (80%)		Yes
Form	DHMP ElevateG Basic application (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateG Basic application (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateG Basic SBC (80%)		Yes
Form	DHMP ElevateG Basic SBC (80%)		Yes
Form (revised)	DHMP ElevateG Basic SBC SPANISH		Yes
Form	DHMP ElevateG Basic SBC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateG Basic SBC (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateG Expanded EOC (80%)		Yes
Form	DHMP ElevateG Expanded EOC (80%)		Yes
Form (revised)	DHMP ElevateG Expanded EOC SPANISH		Yes

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	DHMP ElevateG Expanded EOC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateG Expanded EOC (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateG Expanded application (80%)		Yes
Form	DHMP ElevateG Expanded application (80%)		Yes
Form	DHMP ElevateG Expanded application (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateG Expanded application (Limited Cost Sharing Native)		Yes
Form (revised)	DHMP ElevateG Expanded SBC (80%)		Yes
Form	DHMP ElevateG Expanded SBC (80%)		Yes
Form (revised)	DHMP ElevateG Expanded SBC SPANISH		Yes
Form	DHMP ElevateG Expanded SBC (Zero Cost Sharing Native American)		Yes
Form	DHMP ElevateG Expanded SBC (Limited Cost Sharing Native)		Yes
Rate	Rate Manual		Yes

Final Disposition Letter

State Tracking # 278033
Company: Denver Health Plans
Product Line: Individual HMO

Rate Change Summary

Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).

On Exchange Only Plans
Gold: 2
Silver: 2

Rate Methodology

Experience Used for Rate Setting: This is a new issuer plan with no prior experience. Milliman HCG data was used as the basis for setting the Index rate. Milliman-Denver is the actuarial consultant for this filing.

2012 Experience Period Loss Ratio: Not Applicable.

Annual Health Cost Trends: 8.1%.

Risk Adjustment: -13.9% (payments expected from the federal Risk Adjustment Program in 2014).
The Division believed that the issuers expected member profile in 2014 and start-up status warranted their projected high risk level in 2014, and has allowed for these assumed risk program transfers in rating.

Reinsurance Recoveries: -12.1% (payments expected from the federal Reinsurance Program in 2014).

Smoking Factor: 0% same rates for smokers and non-smokers at all ages.

Age Rating: 3.0 to 1.0 age rating factor limits for all adults age 21 and over.

Colorado 2014 Overall Average Premium: $290.65

* Federal Reported 2014 Comparable Average Premium: $290.65

* This is reported on the issuer's CMS URRT Form submitted in HIOS. It represents a standardized average premium calculation that is used by CMS for comparing and gauging premium development. It is not necessarily the actual average premium, which is shown in the line above as Colorado 2014 Overall Average Premium.

Premium Retained to Cover Expenses, Taxes Fees and Profits

Administrative costs: Expenses the insurance company pays to operate this insurance plan.
This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the company's offices and equipment, commissions
to agents to sell and service policies, subsidies to cover legally required plans such as portability, and taxes. 15.48%

Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company. 3.00%

Average premium retention is 22.65% shown as follows:

		% of Premium Retained
	Issuer Primary Expense and Profit Retention	
	Administrative Expenses and Commissions:	15.48%
	Profit and Contingencies:	3.00%
	Net Private Reinsurance:	0.37%
	Investment Income on claim reserves:	0.00%
(A)	Total:	18.85%
	Retention for Additional Required Taxes, Fees and Assessments	
	PPACA Health Insurer Fee:	0.30%
	PPACA Reinsurance Fee:	1.81%
	PPACA CERF Fee:	0.06%
	PPACA Risk Adjustment User Fee:	0.03%
	PPACA PCORI Fee:	0.00%
	Exchange user fees:	1.40%
	Premium Taxes:	0.00%
	Other Fees, Assessments, Taxes:	0.00%
(B)	Total:	3.60%
	Additional Allowed for QI & Member Welfare Section	
	Quality Improvement:	0.20%
	Community Charitable:	
	IT for ICD-10 Conversion (max allowed 0.3%):	
(C)	Total:	0.20%
(D)	Total Premium Retention For All Purposes (A + B + C):	22.65%
(E)	Colorado Conventional Loss Ratio (100% - D):	77.35%
	Federal MLR Loss Ratio Basis: (E + C) / (100% - B - FIT):	80.45%

Sample of Final Premium Levels

	Denver			
	21 Year Old		64 Year Old	
	Low	High	Low	High
Gold	$248.00	$285.01	$744.00	$855.04
Silver	$215.05	$249.54	$645.14	$748.62

Division Objections and Rate Changes During the Review Process

The issuer answered all Division questions and provided support for the rates.

Final Rate Filing Disposition

The Division has filed the rates in their final form after all adjustments.

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/14/2013
Submitted Date	06/14/2013
Respond By Date	06/19/2013

Dear Laurie Goss,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.

Conclusion:

If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/19/2013, which is within 5 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/19/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Rachel Plummer

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/04/2013
Submitted Date	06/04/2013
Respond By Date	06/11/2013

Dear Laurie Goss,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: objection 3: there has to be a descrption even if its a brief one.

Objection 2

Comments: objection 7, Regulation 4-2-11 section 6 (N) PPACA rate filing Procedure (L) DATA REQUIREMENTS: If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product must be provided. If no experience for the new product is available, experience for a comparable product must be provided, including experience data from other carriers used to support the rates. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy.

Conclusion:

.

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/11/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/11/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,
Cathy Gilliland

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/29/2013
Submitted Date	05/29/2013
Respond By Date	06/05/2013

Dear Laurie Goss,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: If there are any excel docs, please also attach them as a PDF doc

Objection 2

Comments: When a Colorado Actuarial Memorandum is attached, please provide: Regulation 4-2-11 section 6 (A)-PPACA rate filing procedure section (A) 5, Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/05/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/05/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Cathy Gilliland

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/22/2013
Submitted Date	05/22/2013
Respond By Date	06/05/2013

Dear Laurie Goss,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk

Objection 2

Comments: Please provide (0%) for the overall rate impacts on the rate rule schedule: Overall % Indicated Change: Overall % Rate Impact: Written Premium Change for this Program: # of Policy Holders Affected for this Program: Written Premium for this Program: Maximum % Change (where required): Minimum % Change (where required.

Objection 3

Comments: Please provide the trend description on the view rate review detail. See other sections are not allowed.

Objection 4

Comments: Please correct the requested filing Mode on the general information tab to file and use.

Objection 5

Comments: Please provide the form numbers on the view rate review detail. See (?) on the view rate review detail for forms.

Objection 6

Comments: Regulation 4-2-11 section 6 (E) Please indicate which of the following PPACA benefits your plan has implemented:
Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA
Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA
Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA
Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA
Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA
Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

Objection 7

Comments: Regulation 4-2-11 section 6 (N) PPACA rate filing Procedure (L) DATA REQUIREMENTS: The memorandum must, at a minimum, include earned premium, loss experience data, average covered lives and number of claims, submitted on a Colorado-only basis for at least 3 years. (Must be provided in excel format)
1. Pharmacy claims data should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any

rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product must be provided. If no experience for the new product is available, experience for a comparable product must be provided, including experience data from other carriers used to support the rates. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy.

4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used as support rates must be included in the filing.

a. For Renewal filings the experience period must include consecutive data no older than six months prior to the filing (submission) date.

b. For new business filings the experience period must include consecutive data no older than six months prior to the filing date.

5. The loss data must be on an incurred basis, including both separately and combined thee accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information about how the number of claims was calculated.

Objection 8

Comments: Regulation 4-2-11 section 6 (P) Actuarial Memo (N), please provide information on an annual basis. These figures should be the same as on the requested rate information for projected premiums and claims.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/05/2013, which is within 14 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/05/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,
Cathy Gilliland

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/15/2013
Submitted Date	05/15/2013
Respond By Date	05/22/2013

Dear Laurie Goss,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please provide the Actuarial Memorandum in a XLS doc. We are not able to download the xlsx doc.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 05/22/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 05/22/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,
Cathy Gilliland

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/19/2013
Submitted Date	06/19/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

See attached Objection 6_14

Related Objection 1

Comments: Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Objections_6_14
Comments:	See attached
Attachment(s):	Response to June 14 objection.pdf Response to June 14 objection.xlsx

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
1	*DHMP ElevateS Basic EOC (70%)*	*COM_MKT_175-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
2	DHMP ElevateS Basic EOC SPANISH	EOC_SPNSH_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
2	*DHMP ElevateS Basic EOC (73%)*	*COM_MKT_176-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
3	DHMP ElevateS Basic application (70%)	APP_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
3	*DHMP ElevateS Basic application (70%)*	*COM_MKT_181-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
4	DHMP ElevateS Basic SBC (70%)	SBC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
4	*DHMP ElevateS Basic SBC (70%)*	*COM_MKT_187-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
5	DHMP ElevateS Basic SBC SPANISH	SBC_SPNSH_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
5	*DHMP ElevateS Basic SBC (73%)*	*COM_MKT_188-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
6	DHMP ElevateS Expanded EOC (70%)	EOC_ENG_DHMP_66699CO0040001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
6	*DHMP ElevateS Expanded EOC (70%)*	*COM_MKT_193-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
7	DHMP ElevateS Expanded EOC SPANISH	EOC_SPNSH_DHMP_66699CO0040001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
7	*DHMP ElevateS Expanded EOC (73%)*	*COM_MKT_194-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
8	DHMP ElevateS Expanded application (70%)	APP_ENG_DHMP_66699CO0040001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
8	*DHMP ElevateS Expanded application (70%)*	*COM_MKT_199-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
9	DHMP ElevateS Expanded SBC (70%)	SBC_ENG_DHMP_66699CO0040001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
9	*DHMP ElevateS Expanded SBC (70%)*	*COM_MKT_205-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
10	DHMP ElevateS Expanded SBC SPANISH	SBC_SPNSH_DHMP_66699CO0040001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
10	*DHMP ElevateS Expanded SBC (73%)*	*COM_MKT_206-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
11	DHMP ElevateG Basic EOC (80%)	EOC_ENG_DHMP_66699CO0030002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
11	*DHMP ElevateG Basic EOC (80%)*	*COM_MKT_211-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
12	DHMP ElevateG Basic EOC SPANISH	EOC_SPNSH_DHMP_66699CO0030002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
12	*DHMP ElevateG Basic EOC (Zero Cost Sharing Native American)*	*COM_MKT_212-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
13	DHMP ElevateG Basic application (80%)	APP_ENG_DHMP_66699CO0030002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
13	*DHMP ElevateG Basic application (80%)*	*COM_MKT_214-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
14	DHMP ElevateG Basic SBC (80%)	SBC_ENG_DHMP_66699CO0030002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
14	*DHMP ElevateG Basic SBC (80%)*	*COM_MKT_217-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
15	DHMP ElevateG Basic SBC SPANISH	SBC_SPNSH_DHMP_66699CO0030002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
15	*DHMP ElevateG Basic SBC (Zero Cost Sharing Native American)*	*COM_MKT_218-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
16	DHMP ElevateG Expanded EOC (80%)	EOC_ENG_DHMP_66699CO0040002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
16	*DHMP ElevateG Expanded EOC (80%)*	*COM_MKT_220-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
17	DHMP ElevateG Expanded EOC SPANISH	EOC_SPNSH_DHMP_66699CO0040002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
17	*DHMP ElevateG Expanded EOC (Zero Cost Sharing Native American)*	*COM_MKT_221-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
18	DHMP ElevateG Expanded application (80%)	APP_ENG_DHMP_66699CO0040002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
18	*DHMP ElevateG Expanded application (80%)*	*COM_MKT_223-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
19	DHMP ElevateG Expanded SBC (80%)	SBC_ENG_DHMP_66699CO0040002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
19	*DHMP ElevateG Expanded SBC (80%)*	*COM_MKT_226-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*
20	DHMP ElevateG Expanded SBC SPANISH	SBC_SPNSH_DHMP_66699CO0040002_20140101	POL	Initial				Date Submitted: 06/19/2013 By: Laurie Goss
Previous Version								
20	*DHMP ElevateG Expanded SBC (Zero Cost Sharing Native American)*	*COM_MKT_227-00*	*POL*	*Initial*				*Date Submitted: 05/13/2013 By: Laurie Goss*

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Laurie Goss

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/07/2013
Submitted Date	06/07/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

We have edited this field in a Post Submission Update

Related Objection 1

Comments: objection 3: there has to be a descrption even if its a brief one.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

This section of regulation 4-2-11 specifies that experience be provided for the product in question, if available, or for a comparable product, if available. There is no experience available to provide for either the filed product or any comparable ones, because:

Denver Health Medical Plan has not previously sold these products, and

The changes caused by the Affordable Care Act make all of Denver Health Medical Plans other existing products not comparable to its proposed 2014 individual products.

Section K of the memorandum contains extensive detail describing how the rates were developed. We would be happy to schedule a phone conversation to discuss our methodology should the Division have specific questions that are not directly addressed in Section K.

Related Objection 2

Comments: objection 7, Regulation 4-2-11 section 6 (N) PPACA rate filing Procedure (L) DATA REQUIREMENTS: If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product must be provided. If no experience for the new product is available, experience for a comparable product must be provided, including experience data from other carriers used to support the rates. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Laurie Goss

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/03/2013
Submitted Date	06/05/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

I have made PDFs of Excel documents and attached them.

Related Objection 1

Comments: If there are any excel docs, please also attach them as a PDF doc

Changed Items:

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rate Sample
Comments:	See attached
Attachment(s):	State of Colorado - Rate Sample.xlsx State of Colorado - Rate Sample.pdf
Previous Version	
Satisfied - Item:	*Rate Sample*
Comments:	*See attached*
Attachment(s):	*State of Colorado - Rate Sample.xlsx*

Satisfied - Item:	Actuarial Memorandum PDFs
Comments:	PDFs of each tab on the Actuarial Memorandum (DOI Excel template)
Attachment(s):	Actuarial Memorandum (DOI Excel template) Tab 1.pdf Actuarial Memorandum (DOI Excel template) Tab 2.pdf Actuarial Memorandum (DOI Excel template) Tab 3.pdf Actuarial Memorandum (DOI Excel template) Tab 4.pdf Actuarial Memorandum (DOI Excel template) Tab 5.pdf Actuarial Memorandum (DOI Excel template) Tab 6.pdf Actuarial Memorandum (DOI Excel template) Tab 7.pdf

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rate Sample
Comments:	See attached
Attachment(s):	State of Colorado - Rate Sample.xlsx State of Colorado - Rate Sample.pdf
Previous Version	
Satisfied - Item:	*Rate Sample*
Comments:	*See attached*
Attachment(s):	*State of Colorado - Rate Sample.xlsx*

Satisfied - Item:	Actuarial Memorandum PDFs
Comments:	PDFs of each tab on the Actuarial Memorandum (DOI Excel template)
Attachment(s):	Actuarial Memorandum (DOI Excel template) Tab 1.pdf Actuarial Memorandum (DOI Excel template) Tab 2.pdf Actuarial Memorandum (DOI Excel template) Tab 3.pdf Actuarial Memorandum (DOI Excel template) Tab 4.pdf Actuarial Memorandum (DOI Excel template) Tab 5.pdf Actuarial Memorandum (DOI Excel template) Tab 6.pdf Actuarial Memorandum (DOI Excel template) Tab 7.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

See attached.

Related Objection 2

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Comments: When a Colorado Actuarial Memorandum is attached, please provide: Regulation 4-2-11 section 6 (A)-PPACA rate filing procedure section (A) 5, Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuartial Memorandum addendum
Comments:	See attached for Objection #2 from 5/29/13
Attachment(s):	Objection_2_5_29_13.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Laurie Goss

SERFF Tracking #:	DVHH-129023224	**State Tracking #:**	278033	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Denver Health Medical Plan, Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO		
Product Name:	Elevate by Denver Health Medical Plan, Inc.		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/03/2013
Submitted Date	06/03/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

Thank you very much for this information.

Related Objection 1

Comments: Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

We have edited this information in the Post Submission Update. It now says 0% in all these cells (these are new products without any existing rates against which the proposed rates can be compared.)

Related Objection 2

Comments: Please provide (0%) for the overall rate impacts on the rate rule schedule: Overall % Indicated Change: Overall % Rate Impact: Written Premium Change for this Program: # of Policy Holders Affected for this Program: Written Premium for this Program: Maximum % Change (where required): Minimum % Change (where required.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

We planned to include the trend description on the view rate review detail area, but unfortunately the field in SERFF has a length limit and will not allow us to fully enter the requested information. Therefore, while not ideal, please see section L or let us know what workaround we should employ.

Related Objection 3

Comments: Please provide the trend description on the view rate review detail. See other sections are not allowed.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments:

We have edited this field in the Post Submission Update.

Related Objection 4

Comments: Please correct the requested filing Mode on the general information tab to file and use.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments:

We have added this information in the Post Submission Update.

Related Objection 5

Comments: Please provide the form numbers on the view rate review detail. See (?) on the view rate review detail for forms.

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments:

See attached.

Related Objection 6

Comments: Regulation 4-2-11 section 6 (E) Please indicate which of the following PPACA benefits your plan has implemented:
Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA
Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA
Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA
Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA
Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA
Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	PPACA Benefits
Comments:	See attached
Attachment(s):	PPACA Benefits.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments:

These are new products without any prior experience, consistent with our response Section L of the actuarial memorandum. Section K of the actuarial memorandum provides a detailed description of the process by which the proposed rates were developed.

Related Objection 7

Comments: Regulation 4-2-11 section 6 (N) PPACA rate filing Procedure (L) DATA REQUIREMENTS: The memorandum must, at a minimum, include earned premium, loss experience data, average covered lives and number of claims, submitted on a Colorado-only basis for at least 3 years. (Must be provided in excel format)
1. Pharmacy claims data should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.
2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.
3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product must be provided. If no experience for the new product is available, experience for a comparable product must be provided, including experience data from other carriers used to support the rates. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the existing policy form experience will be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a new policy.
4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used as support rates must be included in the filing.
a. For Renewal filings the experience period must include consecutive data no older than six months prior to the filing (submission) date.
b. For new business filings the experience period must include consecutive data no older than six months prior to the filing date.
5. The loss data must be on an incurred basis, including both separately and combined thee accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information about how the number of claims was calculated.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 8

Comments:

See attached.

Related Objection 8

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Comments: Regulation 4-2-11 section 6 (P) Actuarial Memo (N), please provide information on an annual basis. These figures should be the same as on the requested rate information for projected premiums and claims.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Benefits Ratio Projection
Comments:	See attached
Attachment(s):	Benefits Ratio Projection.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Laurie Goss

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/15/2013
Submitted Date	05/15/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

I have re-saved the document as xls. It did say some of the features may not work in this format. If you have issues, please let me know.

Related Objection 1

Comments: Please provide the Actuarial Memorandum in a XLS doc. We are not able to download the xlsx doc.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	see new document
Attachment(s):	DHMP Part III memorandum 5-10-2013.pdf Actuarial Memorandum (DOI Excel template).xlsx Actuarial memorandum - DHMP individual products 5-10-2013.pdf Actuarial Memorandum (DOI Excel template).xls
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	*see attached*
Attachment(s):	*DHMP Part III memorandum 5-10-2013.pdf* *Actuarial Memorandum (DOI Excel template).xlsx* *Actuarial memorandum - DHMP individual products 5-10-2013.pdf*

SERFF Tracking #:	DVHH-129023224	**State Tracking #:**	278033	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Denver Health Medical Plan, Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO		
Product Name:	Elevate by Denver Health Medical Plan, Inc.		
Project Name/Number:	/		

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Laurie Goss

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

Post Submission Update Request Processed On 08/01/2013

Status:	Allowed
Created By:	Laurie Goss
Processed By:	Nichole Boggess
Comments:	

Company Rate Information:

Company Name:Denver Health Medical Plan, Inc.

Field Name	Requested Change	Prior Value
Trend Factors:	The historical experience data required by Regulation 4-2-11, Section 6L, are not available for this filing because these are new products. The rates for these products were developed based on the 2012 HCGs. In order to produce claim costs on a 2014 basis, it was necessary to trend the claim cost projections by two years. The following medical trend assumptions were used: Inpatient facility, 7.0%. Outpatient facility, 9.7%. Professional and other, 7.6%. Prescription drugs, 8.1%. These trend rates represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. These are medical trend rates only. More detail can be found in the actuarial memorandum, Section L.	See Section L, labelled Trend, in the Actuarial Memorandum.

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

Post Submission Update Request Processed On 06/04/2013

Status:	Allowed
Created By:	Laurie Goss
Processed By:	Cathy Gilliland
Comments:	

General Information:

Field Name	Requested Change	Prior Value
Requested Filing Mode	File & Use	Review & Approval

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

Company Rate Information:

Company Name:Denver Health Medical Plan, Inc.

Field Name	Requested Change	Prior Value
Overall % Indicated Change	0.000%	
Overall % Rate Impact	0.000%	
Written Premium Change for this Program	$0	
# of Policy Holders Affected for this Program	0	
Written Premium for this Program	$0	
Maximum %Change (where required)	0.000%	
Minimum %Change (where required)	0.000%	

FORMS:

State: *Colorado* **Filing Company:** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

New Policy Forms:	EOC_ENG_DHMP_66699CO0030001_20140101; EOC_SPNSH_DHMP_66699CO0030001_20140101; EOC_ENG_DHMP_66699CO0030002_20140101; EOC_SPNSH_DHMP_66699CO0030002_20140101; EOC_ENG_DHMP_66699CO0040001_20140101; EOC_SPNSH_DHMP_66699CO0040001_20140101; EOC_ENG_DHMP_66699CO0040002_20140101; EOC_SPNSH_DHMP_66699CO0040002_20140101; SBC_ENG_DHMP_66699CO0030001_20140101; SBC_SPNSH_DHMP_66699CO0030001_20140101; SBC_ENG_DHMP_66699CO0030002_20140101; SBC_SPNSH_DHMP_66699CO0030002_20140101; SBC_ENG_DHMP_66699CO0040001_20140101; SBC_SPNSH_DHMP_66699CO0040001_20140101; SBC_ENG_DHMP_66699CO0040002_20140101; SBC_SPNSH_DHMP_66699CO0040002_20140101; APP_ENG_DHMP_66699CO0030001_20140101; SBC_SPNSH_DHMP_66699CO0030001_20140101; APP_ENG_DHMP_66699CO0030002_20140101; SBC_SPNSH_DHMP_66699CO0030002_20140101; APP_ENG_DHMP_66699CO0040001_20140101; SBC_SPNSH_DHMP_66699CO0040001_20140101; APP_ENG_DHMP_66699CO0040002_20140101; SBC_SPNSH_DHMP_66699CO0040002_201	Evidence of Coverage, Summary of Benefits and Application for all four plans

State: *Colorado* **Filing Company:** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

	40101;
HMO - Covered Lives	0
HMO - Policy Holders	0

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		DHMP ElevateS Basic EOC (70%)	EOC_ENG_DHMP_66699CO0030001_20140101	POL	Initial			
2		DHMP ElevateS Basic EOC SPANISH	EOC_SPNSH_DHMP_66699CO0030001_20140101	POL	Initial			
3		DHMP ElevateS Basic EOC (87%)	COM_MKT_177-00	POL	Initial			
4		DHMP ElevateS Basic EOC (94%)	COM_MKT_178-00	POL	Initial			
5		DHMP ElevateS Basic EOC (Zero Cost Sharing Native American)	COM_MKT_179-00	POL	Initial			
6		DHMP ElevateS Basic EOC (Limited Cost Sharing Native)	COM_MKT_180-00	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
7		DHMP ElevateS Basic application (70%)	APP_ENG_DHMP_66699CO0030001_20140101	POL	Initial			
8		DHMP ElevateS Basic application (73%)	COM_MKT_182-00	POL	Initial			
9		DHMP ElevateS Basic application (87%)	COM_MKT_183-00	POL	Initial			
10		DHMP ElevateS Basic application (94%)	COM_MKT_184-00	POL	Initial			
11		DHMP ElevateS Basic application (Zero Cost Sharing Native American)	COM_MKT_185-00	POL	Initial			
12		DHMP ElevateS Basic application (Limited Cost Sharing Native)	COM_MKT_186-00	POL	Initial			
13		DHMP ElevateS Basic SBC (70%)	SBC_ENG_DHMP_66699CO0030001_20140101	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
14		DHMP ElevateS Basic SBC SPANISH	SBC_SPNSH_DHMP_66699CO0030001_20140101	POL	Initial			
15		DHMP ElevateS Basic SBC (87%)	COM_MKT_189-00	POL	Initial			
16		DHMP ElevateS Basic SBC (94%)	COM_MKT_190-00	POL	Initial			
17		DHMP ElevateS Basic SBC (Zero Cost Sharing Native American)	COM_MKT_191-00	POL	Initial			
18		DHMP ElevateS Basic SBC (Limited Cost Sharing Native)	COM_MKT_192-00	POL	Initial			
19		DHMP ElevateS Expanded EOC (70%)	EOC_ENG_DHMP_66699CO0040001_20140101	POL	Initial			
20		DHMP ElevateS Expanded EOC SPANISH	EOC_SPNSH_DHMP_66699CO0040001_20140101	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
21		DHMP ElevateS Expanded EOC (87%)	COM_MKT_195-00	POL	Initial			
22		DHMP ElevateS Expanded EOC (94%)	COM_MKT_196-00	POL	Initial			
23		DHMP ElevateS Expanded EOC (Zero Cost Sharing Native American)	COM_MKT_197-00	POL	Initial			
24		DHMP ElevateS Expanded EOC (Limited Cost Sharing Native American)	COM_MKT_198-00	POL	Initial			
25		DHMP ElevateS Expanded application (70%)	APP_ENG_DHMP_66699CO00400 01_20140101	POL	Initial			
26		DHMP ElevateS Expanded application (73%)	COM_MKT_200-00	POL	Initial			
27		DHMP ElevateS Expanded application (87%)	COM_MKT_201-00	POL	Initial			
28		DHMP ElevateS Expanded application (94%)	COM_MKT_202-00	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
29		DHMP ElevateS Expanded application (Zero Cost Sharing Native American)	COM_MKT_203-00	POL	Initial			
30		DHMP ElevateS Expanded application (Limited Cost Sharing Native American)	COM_MKT_204-00	POL	Initial			
31		DHMP ElevateS Expanded SBC (70%)	SBC_ENG_DHMP_66699CO0040001_20140101	POL	Initial			
32		DHMP ElevateS Expanded SBC SPANISH	SBC_SPNSH_DHMP_66699CO0040001_20140101	POL	Initial			
33		DHMP ElevateS Expanded SBC (87%)	COM_MKT_207-00	POL	Initial			
34		DHMP ElevateS Expanded SBC (94%)	COM_MKT_208-00	POL	Initial			
35		DHMP ElevateS Expanded SBC (Zero Cost Sharing Native American)	COM_MKT_209-00	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
36		DHMP ElevateS Expanded SBC (Limited Cost Sharing Native American)	COM_MKT_210-00	POL	Initial			
37		DHMP ElevateG Basic EOC (80%)	EOC_ENG_DHMP_66699CO0030002_20140101	POL	Initial			
38		DHMP ElevateG Basic EOC SPANISH	EOC_SPNSH_DHMP_66699CO0030002_20140101	POL	Initial			
39		DHMP ElevateG Basic EOC (Limited Cost Sharing Native)	COM_MKT_213-00	POL	Initial			
40		DHMP ElevateG Basic application (80%)	APP_ENG_DHMP_66699CO0030002_20140101	POL	Initial			
41		DHMP ElevateG Basic application (Zero Cost Sharing Native American)	COM_MKT_215-00	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
42		DHMP ElevateG Basic application (Limited Cost Sharing Native)	COM_MKT_216-00	POL	Initial			
43		DHMP ElevateG Basic SBC (80%)	SBC_ENG_DHMP_66699CO0030002_20140101	POL	Initial			
44		DHMP ElevateG Basic SBC SPANISH	SBC_SPNSH_DHMP_66699CO0030002_20140101	POL	Initial			
45		DHMP ElevateG Basic SBC (Limited Cost Sharing Native)	COM_MKT_219-00	POL	Initial			
46		DHMP ElevateG Expanded EOC (80%)	EOC_ENG_DHMP_66699CO0040002_20140101	POL	Initial			
47		DHMP ElevateG Expanded EOC SPANISH	EOC_SPNSH_DHMP_66699CO0040002_20140101	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
48		DHMP ElevateG Expanded EOC (Limited Cost Sharing Native)	COM_MKT_222-00	POL	Initial			
49		DHMP ElevateG Expanded application (80%)	APP_ENG_DHMP_66699CO0040002_20140101	POL	Initial			
50		DHMP ElevateG Expanded application (Zero Cost Sharing Native American)	COM_MKT_224-00	POL	Initial			
51		DHMP ElevateG Expanded application (Limited Cost Sharing Native)	COM_MKT_225-00	POL	Initial			
52		DHMP ElevateG Expanded SBC (80%)	SBC_ENG_DHMP_66699CO0040002_20140101	POL	Initial			

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
53		DHMP ElevateG Expanded SBC SPANISH	SBC_SPNSH_DHMP_66699CO0040002_20140101	POL	Initial			
54		DHMP ElevateG Expanded SBC (Limited Cost Sharing Native)	COM_MKT_228-00	PJK	Initial			

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	electronic
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Denver Health Medical Plan, Inc.	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	0							
Policy Holders:	0							

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Rate Review Detail

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

COMPANY:

Company Name: Denver Health Medical Plan, Inc.

HHS Issuer Id: 66699

Product Names: Elevate (S) Basic (669CO0030001); Elevate (G) Basic (669CO0030002); , Elevate (S) Expanded (669CO0040001); Elevate (G) Expanded(669CO0040002)

Trend Factors: The historical experience data required by Regulation 4-2-11, Section 6L, are not available for this filing because these are new products. The rates for these products were developed based on the 2012 HCGs. In order to produce claim costs on a 2014 basis, it was necessary to trend the claim cost projections by two years. The following medical trend assumptions were used: Inpatient facility, 7.0%. Outpatient facility, 9.7%. Professional and other, 7.6%. Prescription drugs, 8.1%. These trend rates represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. These are medical trend rates only. More detail can be found in the actuarial memorandum, Section L.

FORMS:

New Policy Forms: EOC_ENG_DHMP_66699CO0030001_20140101; EOC_SPNSH_DHMP_66699CO0030001_20140101; EOC_ENG_DHMP_66699CO0030002_20140101; EOC_SPNSH_DHMP_66699CO0030002_20140101; EOC_ENG_DHMP_66699CO0040001_20140101; EOC_SPNSH_DHMP_66699CO0040001_20140101; EOC_ENG_DHMP_66699CO0040002_20140101; EOC_SPNSH_DHMP_66699CO0040002_20140101; SBC_ENG_DHMP_66699CO0030001_20140101; SBC _SPNSH_DHMP_66699CO0030001_20140101; SBC _ENG_DHMP_66699CO0030002_20140101; SBC _SPNSH_DHMP_66699CO0030002_20140101; SBC _ENG_DHMP_66699CO0040001_20140101; SBC _SPNSH_DHMP_66699CO0040001_20140101; SBC _ENG_DHMP_66699CO0040002_20140101; SBC _SPNSH_DHMP_66699CO0040002_20140101; APP_ENG_DHMP_66699CO0030001_20140101; SBC _SPNSH_DHMP_66699CO0030001_20140101; APP _ENG_DHMP_66699CO0030002_20140101; SBC _SPNSH_DHMP_66699CO0030002_20140101; APP _ENG_DHMP_66699CO0040001_20140101; SBC _SPNSH_DHMP_66699CO0040001_20140101; APP _ENG_DHMP_66699CO0040002_20140101; SBC _SPNSH_DHMP_66699CO0040002_20140101;

Affected Forms:

Other Affected Forms:

State: *Colorado* ***Filing Company:*** *Denver Health Medical Plan, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Elevate by Denver Health Medical Plan, Inc.*
Project Name/Number: */*

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 94,763
Benefit Change: None
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 27,543,060.00
Projected Incurred Claims: 28,183,056.00
Annual $: Min: 136.56 Max: 855.04 Avg: 290.65

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual		New		DHMP rate manual for individual products.xlsx,

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Attachment DHMP rate manual for individual products.xlsx is not a PDF document and cannot be reproduced here.

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Supporting Document Schedules

Bypassed - Item:	HR-1 Form (H)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	see new document
Attachment(s):	DHMP Part III memorandum 5-10-2013.pdf Actuarial Memorandum (DOI Excel template).xlsx Actuarial memorandum - DHMP individual products 5-10-2013.pdf Actuarial Memorandum (DOI Excel template).xls
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	see attached
Attachment(s):	plan_management_data_templates_unified.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Rate Sample
Comments:	See attached

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Attachment(s):	State of Colorado - Rate Sample.xlsx State of Colorado - Rate Sample.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Benefits Ratio Projection
Comments:	See attached
Attachment(s):	Benefits Ratio Projection.pdf
Item Status:	
Status Date:	

Satisfied - Item:	PPACA Benefits
Comments:	See attached
Attachment(s):	PPACA Benefits.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum PDFs
Comments:	PDFs of each tab on the Actuarial Memorandum (DOI Excel template)
Attachment(s):	Actuarial Memorandum (DOI Excel template) Tab 1.pdf Actuarial Memorandum (DOI Excel template) Tab 2.pdf Actuarial Memorandum (DOI Excel template) Tab 3.pdf Actuarial Memorandum (DOI Excel template) Tab 4.pdf Actuarial Memorandum (DOI Excel template) Tab 5.pdf Actuarial Memorandum (DOI Excel template) Tab 6.pdf Actuarial Memorandum (DOI Excel template) Tab 7.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuartial Memorandum addendum
Comments:	See attached for Objection #2 from 5/29/13

SERFF Tracking #:	*DVHH-129023224*	***State Tracking #:***	*278033*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Denver Health Medical Plan, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Elevate by Denver Health Medical Plan, Inc.*		
Project Name/Number:	*/*		

Attachment(s):	Objection_2_5_29_13.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Objections_6_14
Comments:	See attached
Attachment(s):	Response to June 14 objection.pdf Response to June 14 objection.xlsx
Item Status:	
Status Date:	

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Attachment Actuarial Memorandum (DOI Excel template).xlsx is not a PDF document and cannot be reproduced here.

Attachment Actuarial Memorandum (DOI Excel template).xls is not a PDF document and cannot be reproduced here.

Attachment plan_management_data_templates_unified.xlsm is not a PDF document and cannot be reproduced here.

Attachment State of Colorado - Rate Sample.xlsx is not a PDF document and cannot be reproduced here.

Attachment Response to June 14 objection.xlsx is not a PDF document and cannot be reproduced here.

Denver Health Medical Plan, Inc.
Individual Comprehensive Medical Business
Rate Filing Justification
Part III - Actuarial Memorandum and Certification

I. General Information

Company Identifying Information

Company Legal Name:	Denver Health Medical Plan, Inc.
State:	Colorado
HIOS Issuer ID:	66699
Market:	Individual
Effective Date:	January 1, 2014

Company Contact Information

Primary Contact Name:	Laurie Goss
Primary Contact Telephone Number:	(303) 602-2065
Primary Contact Email-Address:	laurie.goss@dhha.org

II. Proposed Rate Increase(s)

This submission is for new products available for sale January 1, 2014. Denver Health Medical Plan, Inc. (DHMP) is a new entrant to the individual market, and therefore there are currently no individual policies, certificates, or covered lives. Because these are new products, there are no proposed rate increases as there were no prior products against which to compare these rates.

Because no prior claim experience was available for this product, the Milliman *Health Cost Guidelines*™ cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of DHMP's market given underwriting, rating, and benefit requirements effective January 1, 2014, under the Patient Protection and Affordable Care Act (ACA);
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

Each of these factors is discussed in more detail later in this memorandum.

III. Experience Period Premium and Claims

Claims Paid Through Date

DHMP is a new carrier in the individual market, and as such does not have any prior claim experience. Therefore, no paid claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Premiums (net of MLR Rebate) in Experience Period

DHMP is a new carrier in the individual market, and as such has not collected any prior premiums in this market. Therefore, no experience period premium information is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Allowed and Incurred Claims Incurred During the Experience Period

DHMP is a new carrier in the individual market, and as such does not have any prior claim experience. Therefore, no allowed and incurred claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period. Premiums were developed using a credibility manual rating approach.

IV. Benefit Categories

DHMP is a new carrier in the individual market, and as such does not have any prior claim experience in the individual market. Therefore, no claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Because no prior claim experience was available for this product, the Milliman *Health Cost Guidelines* (HCGs) cost and utilization information was used in the development of these rates.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to

anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Capitation
- Prescription Drug

V. Projection Factors

DHMP is a new carrier in the individual market, and as such does not have any prior claim experience. Therefore, as mentioned previously, we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates. This section describes the projection factors we used with the HCGs to develop the credibility manual rates for the projection period.

Projections and Adjustments Made to the Data

Because the process for projecting and adjusting the data used to estimate the claim costs for these products involved a number of steps that are interrelated, the entire process is described here and will be used for reference throughout this document.

Claim costs for proposed plans were developed using the Milliman HCGs, with adjustments to reflect the relative value of DHMP's individual experience compared to the Milliman HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA.

We followed the steps below to adjust the Milliman *Health Cost Guidelines* claim experience to be on an appropriate basis for premiums for DHMP.

Step 1: Project Total Colorado Market Members and Health Status by Population Cohort

We expect significant shifts in the demographics and health status of the insured population when the health insurance Exchange opens in 2014. We projected Colorado statewide population demographics and health status to help determine DHMP's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.

- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Colorado.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual and SHOP Exchanges (i.e., "take up" rates). The Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an individual Exchange plan.

We then applied employer-sponsored insurance transition rates, small group, and individual / uninsured Exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For DHMP's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and Exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

Step 2: Project DHMP Enrollment by Market, Exchange Status, and Product

We projected DHMP's expected 2014 individual product enrollment on the exchange based on our estimate of the statewide population and DHMP's likely share of the total based on our assumed price relativity and appeal. We estimated the members that would select each of DHMP's benefit plans based on the plans for which they would qualify (given their age and income level) and assumed 8% of these members are tobacco users. We also assumed that all 2014 members are enrolled for the entire year.

Step 3: Claim Cost Projection

The basis used to develop rates for these new products is the 2012 Milliman *Health Cost Guidelines*. The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

Step 4: Adjustment for Changes in Morbidity

The data in the *Guidelines* is for a large group population. We believe this is a more appropriate basis for the development of future individual premium rates than current individual claim levels because large group experience includes a breadth of covered benefits consistent with those in the Essential Health Benefits (EHBs), and the impact of selection or medical underwriting present in the current individual market is mitigated by using non-underwritten large group experience. The *Guidelines* are based on the 2012 large group population. We project that the 2014 individual market population will have a different population profile than the current large group market, and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the large group claims to represent our estimate of the market average demographics and morbidity of the 2014 individual market.

As mentioned previously, through our population modeling we developed an estimate that the 2014 individual market will have a 12.2% higher morbidity than the

current large group market, and so applied this adjustment factor to increase the claim costs.

Changes in the Morbidity of the Population Insured

We anticipate significant changes in the average morbidity of this market in 2014 due to ACA provisions effective in January 2014. Please see Step 4 in the "Projections and Adjustments Made to the Data" section above for a description of the development of the adjustment factor.

The projection factor of "Pop'l risk Morbidity" shown in Worksheet 1, Section II reflects the impact of the shift in mix over time. This projection factor was calculated based on our projection from the current credibility manual experience to the 2014 individual market morbidity. Note that this factor does not include the impact of changes in demographics to ensure that demographic shift is not counted twice.

Changes in Benefits

The underlying utilization and charge levels assumed in the 2012 Milliman *Health Cost Guidelines* baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out of pocket maximum. Adjustments were then made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been created by studying the historical impact of different contractual limitations and cost sharing on utilization experience by the covered population.

The adjustments we used to develop utilization rates consistent with these products are as follows:

- Starting with large group experience enables us to capture the impact of removal of underwriting and pre-existing condition exclusions in the current individual market, post 2014.
- Adjusted for the difference between the current (2012) large group and future (2014) individual market average risk status. This analysis involved a study of morbidity levels and relied on Current Population Survey (CPS) data. The analysis is described in Step 4 of the previous section.
- Adjusted for differences in benefit designs (e.g., metallic levels).
- Adjusted for changes from mandated benefits (e.g., EHBs)

Changes in Demographics

We expect significant shifts in the insured population when the health insurance Exchange opens in 2014. We projected Colorado statewide population demographics and health status to help determine DHMP's share of the market.

Because we are using the HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 in the "Projections and Adjustments Made to the Data" section above for more details for these adjustments.

Other Adjustments

Because we are using the HCGs as the basis for these premiums, there are additional adjustments necessary to put the claim experience on a consistent basis with these products. Please see Steps 1-4 in the "Projections and Adjustments Made to the Data" section for more details surrounding additional adjustments we made.

Annualized Trend Factors

The utilization and cost trend factors shown in Worksheet 1, Section II are reflective of an aggregate allowed cost trend of 8.1%. This aggregate value was developed based on the Milliman *Health Cost Guidelines* and general industry knowledge regarding recent trends in medical inflation.

Separate factors for utilization and cost were developed based on relative values from the Milliman *Health Cost Guidelines*. These factors result in an aggregate value of 8.1%.

These trend assumptions are based on the utilization and cost per service trends developed from claims data for the *Guidelines*. We have reviewed these trend assumptions and believe they are reasonable for this purpose. The trend assumptions above do not include the impact of changes in demographics, benefit design, or morbidity since those are captured elsewhere in the development of the index rate.

VI. Credibility Manual Rate Development

DHMP is a new carrier in the individual market, and as such does not have any prior claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates.

Source and Appropriateness of Experience Data Used

The base experience for the proposed plans was composed of claim costs developed using the 2012 Milliman *Health Cost Guidelines*, chosen to reflect the demographic and unit cost differences specific to Colorado, as well as DHMP's plan benefit designs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA. The *Health Cost*

Guidelines are described in sections “IV Benefit Categories” and “Projections and Adjustments Made to the Data” above.

Adjustments Made to the Data

Adjustments made to the *Health Cost Guidelines* to create estimated claim costs for these products are described in detail in section “Projections and Adjustments Made to the Data” above.

Inclusion of Capitation Payments

The HCGs are based on nationwide claim experience, which include a complete picture for incurred and allowed dollars. These data include relevant capitation payments as part of the underlying claim experience. We anticipate that approximately 70% of medical (non-pharmacy) costs will be subject to a capitation arrangement between DHMP and Denver Health and Hospital Authority.

Portion of Cost Payable by HHS’s Fund on Behalf of Insureds

Because of the cost sharing reduction (CSR) provisions, HHS will pay a portion of these costs on behalf of members. We have estimated these costs based on our estimated enrollment of CSR eligible members. We have expressed this amount as a percentage of cost in Worksheet 2. The amount of the subsidy was calculated by projecting enrollment in each CSR silver plan. As described above, we computed the projected allowed claim costs for each cohort of individual enrollees under the assumption that the benefit design was the standard (70% AV) silver plan. We increased this projected allowed amount for the impact of induced utilization, using the factors released by CMS for the purpose of applying the federal risk adjustment formula. Then, for each CSR plan, we computed the percentage point difference in actuarial value between the CSR plan and the standard silver plan (e.g., 24 points for the 94% plan, 17 points for the 87% plan, and 3 points for the 73% plan). The product of that difference and the projected allowed claim cost equals the amount of the subsidy provided by HHS.

VII. Credibility of Experience

DHMP is a new carrier in the individual market, and as such does not have any prior claim experience. Therefore, as mentioned previously, we used the Milliman *Health Cost Guidelines* with adjustments as the basis for the Credibility Manual rates and have given them 100% credibility weight.

VIII. Paid to Allowed Ratio

The Paid to Allowed ratio shown in Worksheet 1, Section II of the URRT was developed as our best estimate of the impact of member cost sharing. We developed allowed claim costs, and used the Milliman HCGs to develop the

expected portion of per member per month (PMPM) claims that are covered by the plan versus the member to develop the paid to allowed ratio. The paid to allowed ratio was developed as follows:

$$\frac{Weighted\ Average\ Paid\ Claim\ PMPM\ estimate}{Weighted\ Average\ Allowed\ Claim\ PMPM\ Estimate}$$

IX. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

DHMP recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, DHMP must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of DHMP's plans in this risk pool.

Since differences between DHMP's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must not be included in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which DHMP's actual block of business differs from the market will be accounted for through these transfer payments rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of DHMP's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at DHMP's expected morbidity level. The difference between the market average risk pool and DHMP's expected morbidity is our estimate of what the transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected statewide risk scores (to estimate DHMP's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred

relative health status factors for age / gender claim cost factors from Milliman's *Health Cost Guidelines* to produce final statewide average risk scores for each population cohort.

Project DHMP's Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected DHMP's risk scores (to estimate DHMP's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between DHMP and the overall Colorado market. Selection refers to the health status difference between a given carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

We estimated statewide claim costs (to estimate the statewide premium in DHMP's risk adjustment transfer payment) by applying the steps above to estimate the PMPM claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. DHMP is not selling platinum or bronze products, but we did assume some percentage of take-up of those plans in the marketplace as a whole.

Estimate DHMP's Risk Adjustment Transfer Payment

We estimated DHMP's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, DHMP's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether DHMP receives or makes a transfer payment is how DHMP's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding DHMP's expenses to the statewide average claim costs described above. Next, we normalized DHMP's risk score to the statewide average risk score and removed the portion of DHMP's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received by DHMP.

Projected ACA Reinsurance Recoveries Net of Reinsurance

Carriers pay contributions for the ACA reinsurance program, estimated to be $5.25 PMPM in 2014. Consistent with the Part III Actuarial Memorandum instructions, which state that this line item must be reported net of reinsurance contributions, we have included this payment on Worksheet 1, Section II of the URRT.

We assumed the individual market will receive 80% of all individual members' PMPY incurred claims between $60,000 and $250,000. We estimated this value by calibrating the claims probability distributions (CPDs) from the HCGs for each of DHMP's individual benefit plans' estimated PMPM claims costs.

Projected PMPM ACA Reinsurance Recoveries in Worksheet 1, Section II of the URRT were calculated as follows:

- (Projected PMPM Incurred Claims before Risk Adjuster and Recoveries * 10.46%) - $5.25

Projected allocations across plans are calculated as follows:

- Allocation % for Plan X =
  Projected Plan Premium before Reins / Total Plan Premium before Reins

- PMPM Allocation for Plan X = Total Recoveries * Allocation % for Plan X

X. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

Administrative expenses were developed on a PMPM basis using DHMP's projections for costs of operating its business in 2014, including the impact of general expense inflation. The value entered in Worksheet 1, Section II of the URRT illustrates this value as a percent of the index rate.

Profit & Risk Load

Profit and Risk Load target values were determined as an aggregate value for the single-risk pool based on company targets and consideration for federal MLR requirements. The value entered in Worksheet 1, Section II of the URRT illustrates this value as a percent of the index rate.

Taxes and Fees

Table 2 provides a breakdown of projected taxes and fees illustrated in Worksheet 1, Section II of the URRT.

Table 2 Projected Taxes and Fees			
Item	**% Premium**	**PMPM**	**% of Index Rate**
Premium Tax	0.00%	$0.00	0.00%
Health Insurer Fee	0.30%	$0.87	0.21%
Comparative Effectiveness Research	0.06%	$0.17	0.04%
Risk Adjustment Admin Fee	0.03%	$0.08	0.02%
Exchange User Fee	1.40%	$4.07	0.99%
Total	1.79%	$5.19	1.26%

XI. Projected Loss Ratio

The projected loss ratio based on the federally prescribed MLR methodology is 80.8%. The numerator of the projected MLR contains projected claim costs and quality improvement expenses, net of receipts from the risk adjuster, reinsurance, and risk corridors programs. The denominator consists of total premiums, net of premium taxes and regulatory fees. A credibility adjustment is then applied to account for the small size of DHMP's projected enrollment. The following demonstrates our projection of DHMP's MLR, using the federal definition but not including any credibility adjustment (which could only increase the MLR):

$$80.8\% = \frac{\$297.41\ claims + \$0.59\ QI\ expense - \$41.47\ risk\ adjuster - \$25.85\ reinsurance}{\$290.65\ premium - \$5.19\ taxes\ \&\ fees}$$

XII. Index Rate

As previously discussed, DHMP is a new carrier and as such does not have prior claim experience to use to develop an experience period index rate. We used a credibility manual approach, in which the base claims did not include cost for items which are not EHBs, and therefore did not need to be adjusted for the removal of non-EHBs.

The projected index rate includes the projected claim level for the projection period, including all adjustments for trend, benefit and demographic differences. It reflects the experience for all of the products we are developing since they are within a single risk pool. The projected index rate shown in Worksheet 1, Section II of the URRT was developed as follows:

Projected Allowed Claims PMPM x % of Allowed Claims Attributable to EHB

Projected allowed claims are those after credibility adjustments, but before any adjustment for risk adjuster or reinsurance payments and/or recoveries.

Development of Plan Level Rates

Plan level rates are developed based on the following approach:

Adjusted Index Rate =
- Index Rate
- +/- Risk Adjustment Payment
- +/- Reinsurance Recoveries net of Fees
- + User Exchange Fees

Plan Level Rate =
- Adjusted Index Rate
- x Plan actuarial value and cost sharing value factor
- x Administrative costs, excluding user exchange fees

There is no impact due to differences in provider networks, delivery system characteristics, or utilization management practices. All plans use the same network, delivery system, and utilization management practices.

XIII. AV Metal Levels

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed based on the CMS Actuarial Value calculator.

We did not employ an alternate methodology to develop the AV Metal Values.

XIV. AV Pricing Values

The fixed reference plan selected for purposes of developing AV Pricing Values is the Elevate (S) - Basic plan.

Plan factors were derived based on the actuarial value of these products and the age/gender mix of the standard HCG population. Note that the Silver plans have relativities that are formed based on the expected mix of enrollment in the standard plans and their associated CSR plans (73% actuarial value, 87% actuarial value, and 94% actuarial value). Negligible enrollment is expected in the Native American plan variants. The plan factors below do not incorporate differences in morbidity; overall morbidity is reflected in other rating factors and the index rate. Plan factors are presented in the table below:

Product	Rate Factor	URRT AV Pricing Value
Elevate (G) - Basic	1.1532	1.070
Elevate (S) – Basic	1.0000	0.831
Elevate (G) – Expanded	1.3254	1.261
Elevate (S) - Expanded	1.1604	0.998

The following table provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and the portion of the value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2).

Plan	URRT AV Pricing Value	Adjust 1 AV/Cost Share	Adjust 2 Network	Adjust 3 Other Benefits	Adjust 4 Admin Expense	Adjust 5 Catastrophic	Total
Elevate (G) - Basic	1.070	100%	0%	0%	0%	0%	100%
Elevate (S) – Basic	0.831	100%	0%	0%	0%	0%	100%
Elevate (G) – Expanded	1.261	60%	40%	0%	0%	0%	100%
Elevate (S) - Expanded	0.998	2%	98%	0%	0%	0%	100%

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the Milliman *Health Cost Guidelines* to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

XV. Membership Projections

Membership projections, as illustrated in Worksheet 2, Section IV of the URRT were developed by applying an assumed market penetration for DHMP to the total market size estimated as described above in Section V. Our assumed market penetration rate varies by income level.

We assume that the silver product will be significantly more attractive than the gold product, and have accordingly assumed that 90% of DHMP enrollees will select the silver plan (with all members choosing the CSR variant for which they qualify).

XVI. Terminated Products

DHMP is a new entrant to the individual market, and so does not have any current products. Therefore, no products will be terminated.

XVII. Plan Type

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT.

XVIII. Warning Alerts

The following provides additional information regarding differences between the sum of the plan level experience and projections in Worksheet 2, Sections III and IV of the URRT and the total experience and projected amounts found on Worksheet 1 of the URRT:

1. A warning is found in cell A82. This appears to be due to a very minor Excel precision error, as the actual difference between the two cells being tested is $0.000088 out of $27,543,060.
2. A warning is found in cell A99. We believe this is an error in the template's warning alert. The difference between the two cells being tested is exactly the amount of DHMP's projected reinsurance and risk adjuster receipts. The instructions for this section state that the amounts entered in row 86 (Total Allowed Claims) "should be consistent with the total allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries entered in Section III of Worksheet 1." The test, however, compares this amount (net of reinsurance and risk adjustment) with an amount on Worksheet 1 that excludes reinsurance and risk adjustment.

XIX. Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the management of DHMP. To the extent that it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum may be materially affected.

XX. Actuarial Certification

I, Mary van der Heijde, am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of Denver Health Medical Plan, Inc. (the "Company").

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan specific premium rates. The allowable modifiers used to generate plan specific premium rates were based on the following:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the Essential Health Benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents Essential Health Benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.

I certify that the benefits included in DHMP's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Colorado benchmark plans. Pediatric dental coverage was not included in these benefits, due to the expected presence of a standalone dental plan on the exchange.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Signed: Mary van der Heijde

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries

Dated: May 10, 2013

ACTUARIAL CERTIFICATION

Denver Health Medical Plan, Inc.
Individual Rate Filing Effective January 1, 2014

I, Mary van der Heijde, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by Denver Health Medical Plan, Inc. (DHMP) to render this opinion. I meet the Academy qualification standards for rendering the opinion and am familiar with the applicable Colorado statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for individual rate filings. I am qualified to render this opinion under the qualifications set forth in Colorado Insurance Regulation 1-1-1.

In particular, this certification is being prepared to demonstrate compliance with Colorado Regulation 4-2-11, as promulgated under the authority of C.R.S. 10-1-109, 10-3-1110, 10-16-107, 10-16-109, and 10-18-105(2). It is not intended to be used for any other purpose.

Actuarial Certification

To the best of my knowledge, this rate filing is in compliance with the applicable laws and regulations of the State of Colorado in effect as of May 10, 2013, except where those laws and regulations conflict with the Patient Protection and Affordable Care Act and its implementing regulations. In cases where Colorado law or regulation is in conflict with federal law or regulation, this rate filing complies with federal law or regulation or regulatory guidance. In my opinion, the premium rates described in my Actuarial Memorandum dated May 10, 2013, are not excessive, inadequate, or unfairly discriminatory.

_____

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries
May 10, 2013

ACTUARIAL MEMORANDUM

Denver Health Medical Plan, Inc.
Individual Rate Filing Effective January 1, 2014

I, Mary van der Heijde, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by Denver Health Medical Plan, Inc. (DHMP) to prepare this memorandum. I meet the Academy qualification standards for rendering the opinion that accompanies this memorandum (dated May 10, 2013) and am familiar with the applicable Colorado statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for individual rate filings. I am qualified to render this opinion under the qualifications set forth in Colorado Insurance Regulation 1-1-1.

In particular, this memorandum is being prepared to demonstrate compliance with Colorado Regulation 4-2-11, as promulgated under the authority of C.R.S. 10-1-109, 10-3-1110, 10-16-107, 10-16-109, and 10-18-105(2). It is not intended to be used for any other purpose.

The Colorado Division of Insurance (DOI) released a document on May 7, 2013, entitled "PPACA Rate Filing Procedures for Colorado" (hereafter, "the May 7 guidance"). This document describes the desired content of the actuarial memorandum, and it differs in some ways from the instructions in Regulation 4-2-11 as currently in force (version effective February 1, 2013). This memorandum has been prepared using the version of Regulation 4-2-11 that became effective February 1, 2013. The memorandum will note instances where section labels are different in the May 7 guidance. To the extent that the requirements of the regulation are not applicable under federal law and regulations, the memorandum states this in the appropriate section. Where requirements of Regulation 4-2-11 conflict with federal requirements, the federal requirements are assumed to supersede the conflicting provision of state law or regulation.

The May 7 guidance requires that several elements of this memorandum be submitted in Excel format. We have attached an Excel workbook with these elements. The Excel workbook repeats information found in this memorandum, but due to the limitations of the template, it cannot contain all information to completely describe the rates. Some of the required tables are also not applicable to new products. The attached Excel workbook is merely a supplement to this memorandum and should not be read in isolation; the workbook on its own does not constitute an "Actuarial Report" as defined in Actuarial Standard of Practice No. 41.

A. Summary

1. This rate filing is for new products to be sold on the Colorado Health Benefit Exchange (COHBE) starting January 1, 2014.

2. This filing contains the initial rates for this product; because the products are new, this is neither a rate increase nor decrease. As well, there is no renewal history for this product.

3. These products will be marketed using television, radio, out-of-home, and print media, as well as through grassroots outreach and events to educate and inform the community.

4. Under the Patient Protection and Affordable Care Act (PL 111-148 and PL 111-152; hereafter, "ACA"), premiums for the same product may vary among individuals only based on age, tobacco use, family composition, and geographic area (Public Health Service Act, §2701, as amended by the ACA, §1201). The premiums for each product will vary only based on member age.

DHMP has chosen not to vary rates based on tobacco use, and rates do not vary based on geographic area because DHMP's service area is entirely contained within the Denver rating area (as defined in guidance issued by the Colorado Division of Insurance on March 27, 2013).

Federal regulation clarified that for family composition, each family member must be rated as an individual, but no more than three family members under age 21 may be taken into account when calculating the premium for family coverage (45 CFR §147.102(c)). Accordingly, premiums for these products will vary by age, and each individual family member will be rated separately, except that for families with more than three children under age 21, only the first three will be counted.

5. This rate filing covers two products, comprising four plan designs. Each product has two metal level plan designs:

- DHMP will offer two plans with a silver level of coverage, as defined by the ACA, §1302(d): Elevate (S) – Basic and Elevate (S) - Expanded. The cost sharing structure and levels are identical; the only difference is the scope of the provider network. There are several variants of the benefit design for these products, which will be sold to individuals who qualify for each variant. In particular, there are cost sharing reduction (CSR) variants at the 94%, 87%, and 73% actuarial value levels, which will be sold to those who qualify, according to 45 CFR §156.420(a). Also, there are two variants of each available to qualifying Native Americans, as required by 45 CFR §156.420(b): one with no cost sharing (100% actuarial value), and a second with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).

DHMP will offer two plans with a gold level of coverage, as defined by the ACA, §1302(d): Elevate (G) – Basic and Elevate (G) – Expanded. The cost sharing structure and levels are identical; the only difference is the scope of the provider network. Also, there are variants available to qualifying Native Americans, as required by 45 CFR §156.420(b), with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603). Guidance published in the Federal Register, Vol. 78, No. 47, p. 15494 (March 11, 2013) states that in non-FFE states, when a set of plan designs differ only in cost sharing and premium (as is the case for DHMP's products), a zero-cost variant for qualifying Native Americans must only be offered for the lowest-cost plan. Thus, under federal rules, a zero-cost variant is not required for the Gold product. Nonetheless, the Plan & Benefits Template, which must be submitted with this rate filing, automatically creates a zero-cost variant for all plans. It is not DHMP's intent to offer the zero-cost variant at the Gold level unless the DOI or COHBE should require it, since the benefits would be identical to those of the Silver plan but the premium would be higher. The benefit designs are provided in other templates submitted with this rate filing.

Each of these plans provide the essential health benefits (EHB) described in the ACA, §1302. There are no supplemental (non-EHB) benefits. The federal government gave each state the flexibility to choose an EHB package based on one of ten possible benchmark options. Colorado has selected the largest small group plan in the state (Kaiser Foundation Health Plan of Colorado Deductible/Coinsurance HMO 1200D), supplemented by the pediatric dental benefits in the CHP+ program. Neither DHMP product includes a pediatric dental benefit due to the expected presence of a standalone dental plan on COHBE. Under the ACA, §1302(b)(4)(F), a QHP is not required to offer pediatric dental benefits if a stand-alone dental plan is available on the state exchange. The DOI has established a filing deadline for stand-alone dental products that is later than the filing deadline for individual medical plans. Therefore, it cannot be known with certainty as of the filing date that a stand-alone dental plan will be available on COHBE. We would re-file new rates should it become necessary at a later date for DHMP to add pediatric dental benefits (if, for example, no stand-alone dental plan is filed, or none is approved by the DOI, or none is certified by COHBE). DHMP has no intention of offering a pediatric dental benefit in 2014 provided that a stand-alone option is available on COHBE.

Both products follow a closed-panel model, using providers of Denver Health and Hospital Authority (Denver Health) as the network. In the "expanded" products, University Hospital and Children's Hospital are also included in the network, along with their affiliated physicians. Members are required to choose a network primary care physician (PCP). The plans cover services provided by non-network providers only when authorized by DHMP, and for urgent or emergency care. Prescription drug benefits are provided both at the Denver Health pharmacy and at participating network pharmacies, with cost sharing for

members being significantly lower at the Denver Health pharmacy (and certain prescription drugs are only available at the Denver Health pharmacy).

6. A list of all policy forms affected by this rate filing can be found on the forms schedule tab in SERFF.

7. (This is marked as item 6 in the May 7 guidance.) Premiums are charged on an attained-age basis, based on age at the date of policy issuance or renewal. Section K of this memorandum describes age rating in more detail. Colorado Regulation 4-2-11, Section 8A, prohibits attained age rating where the slope of the premium schedule by age is "substantially different from the slope of the ultimate claim cost curve." This requirement conflicts with 45 CFR §147.102(d)-(e), which prescribes a specific premium age curve that may not be similar to the slope of the claim cost curve. This rate filing conforms to the federal requirements.

8. This policy is guaranteed renewable. Premiums are not guaranteed for any period after December 31, 2014.

B. Assumption, Acquisition, or Merger

The products included in this filing are not part of an assumption, acquisition, or merger of policies from or with another company.

C. Rating Period

The rates in this filing will be applicable January 1, 2014. Premiums will not change through the year. These rates will remain in effect until December 31, 2014.

D. Underwriting

No underwriting is applied for these products. These are new products, and therefore contain no grandfathered plans.

E. Effect of Law Changes

This section is labeled Section D in the May 7 guidance.

These are new products and have been designed to conform to all legal and regulatory requirements (federal and state) as of the date of this filing. Because the products are new, there are no prior rates against which changes can be measured. This filing does not account for any laws that may be signed after the date of this memorandum, nor any regulatory changes that may be issued after the date of this memorandum.

F. Rate History

This section is labeled Section E in the May 7 guidance.

These are new products, so there is no rate history available. The Rates Template, uploaded elsewhere in SERFF, contains the proposed 2014 rates for each combination of plan design and age.

G. Coordination of Benefits

This section is labeled Section F in the May 7 guidance.

Because these are new products, there is no historical experience available. The projections of future claim costs are for DHMP's liability, net of any amounts that may be recoverable from other parties.

H. Relation of Benefits to Premium

This section is labeled Section G in the May 7 guidance.

The targeted loss ratio is 88.06% for each product. The retention components are as follows:

Table 1 – Retention components	
Component	**Percent of Premium**
General administrative expenses	15.48%
Quality improvement expenses	0.20%
Stop-loss reinsurance premium, net of recoveries	0.37%
Transitional reinsurance premium, net of recoveries	-8.90%
Exchange administrative fee	1.40%
Comparative effectiveness research fee	0.06%
Health insurer fee (ACA §9010, as amended)	0.30%
Risk adjustment administrative fee	0.03%
Investment income on reserves	0.00%
Provision for profit and contingencies	3.00%
Total	**11.94%**

Investment income from claim reserves are included in the provision for profit and contingencies line and are expected to be immaterial in 2014.

Note that the total in the bottom row of Table 1 is not the same as the medical loss ratio that would be computed under federal rules for the purpose of determining whether a rebate is owed to members.

I. Lifetime Loss Ratio

These products are not priced using a lifetime loss ratio.

J. Provision for Profit and Contingencies

This section is labeled Section H in the May 7 guidance.

DHMP's provision for profit and contingencies is 3% of premium, as shown in section H. Section K explains how this provision is included in the premiums. Investment income on reserves is not expected to be material.

K. Complete explanation as to how the proposed Rates were developed

This section is labeled Section I in the May 7 guidance.

BACKGROUND

Under federal rules implementing the ACA (published in the Federal Register February 27, 2013, Vol. 78, No. 39, pp. 13406-13442), insurance issuers in the individual market must follow a prescribed set of guidelines in setting premiums. The basic approach is to develop a "market-wide index rate," which is applicable to all plans if the issuer sells in the individual market. To that index rate, multiplicative adjustment factors are applied to calculate an individual member's premium. Those adjustment factors are:

- Plan selection factor (due to actuarial value and cost sharing design, provider network, delivery system, and utilization management practices, benefits in addition to EHBs, administrative costs, and characteristics of catastrophic plans)

- Age factor
- Geographic area factor
- Tobacco use factor

For the products in this rate filing, only the index rate, plan selection factors, and age factors are relevant, because DHMP only operates in a single geographic area of the state and has elected not to use a tobacco factor.

This section of the memorandum describes the process we followed to develop the index rate for DHMP's individual products and the plan-specific adjustment factors.

In this context, an index rate is not the average claim cost or average premium for the projected insured population. Rather, the index rate is a base rate to which the factors above are applied to arrive at a premium for an individual member. It would not be mathematically possible for the index rate to represent a market average premium or claim cost for the entire insured population, because the set of age factors required by law does not have a 1.00 average (when weighted across the age profile of the insured population). The projected average claim costs and premium for this population can be found in Table 2 below, but the index rate is something different from either of these (as shown in the last row of Table 2).

DATA

Because DHMP has no prior individual product claim experience, there is no actual DHMP claim experience available for these products. The Milliman *Health Cost Guidelines*™ (HCG) cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of DHMP's market given underwriting, rating, and benefit requirements effective January 1, 2014, under the ACA;
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Prescription Drug

Claim costs for proposed plans were developed using the HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA. We followed the steps below to adjust the HCG claim experience to be on an appropriate basis for premiums for DHMP and to calculate the market-wide index rate and the plan-level adjustments.

STEP 1: PROJECT TOTAL COLORADO MARKET MEMBERS AND HEALTH STATUS BY POPULATION COHORT

We expect significant shifts in the demographics and health status of the insured population when COHBE begins to operate in 2014. We projected Colorado statewide population demographics and health status to help determine DHMP's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.
- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Colorado.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual Exchange (i.e., "take up" rates). The exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an exchange plan.

We then applied employer-sponsored insurance transition rates and individual/uninsured exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For DHMP's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

STEP 2: PROJECT DHMP ENROLLMENT BY MARKET, EXCHANGE STATUS, AND PRODUCT

We projected DHMP's expected 2014 individual product enrollment on the exchange based on our estimate of the statewide population and DHMP's likely share of the total based on our assumed price relativity and appeal. We estimated the members that would select each of DHMP's benefit plans based on the plans for which they would qualify (given their age and income level) and assumed 8% of these members are tobacco users. We also assumed that all 2014 members are enrolled for the entire year.

STEP 3: CLAIM COST PROJECTION

The basis used to develop rates for these new products is the 2012 HCGs. All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Colorado-specific unit cost and utilization basis.

STEP 4: ADJUSTMENT FOR CHANGES IN MORBIDITY

The data in the HCGs are for a large group population. We believe this is a more appropriate basis for the development of future individual premium rates than current individual claim levels because large group experience includes a breadth of covered benefits consistent with those in the EHBs, and the impact of selection or medical underwriting present in the current individual market is mitigated by using non-underwritten large group experience. The HCGs are based on the 2012 large group population. We project that the 2014 individual market population will have a different population profile than the 2012 large group market and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the 2012 large group claims to represent our estimate of the market average demographics and morbidity of the 2014 individual market.

We projected statewide risk scores by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort. We developed an estimate that the 2014 individual market will have a 12.2% higher morbidity than the 2012 large group market, and so applied this adjustment factor to increase the claim costs. Note that this factor does not include the impact of changes in demographics, to ensure that demographic shift is not counted twice.

STEP 5: CHANGES IN BENEFITS

The underlying utilization and charge levels assumed in the 2012 HCG baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out-of-pocket-maximum. Adjustments were made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been developed by studying the historical impact of different contractual limitations and cost sharing on utilization experience of the covered population.

STEP 6: CHANGES IN DEMOGRAPHICS

We expect significant shifts in the demographics of the insured population when COHBE opens in 2014. We projected Colorado statewide population demographics and health status to help determine DHMP's share of the market. Because we are using the 2012 HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 above for more detail on these projections.

STEP 7: ESTIMATE IMPACT OF RISK ADJUSTMENT

DHMP recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, DHMP must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant

multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of DHMP's plans in this risk pool.

Since differences between DHMP's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must be adjusted for in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which DHMP's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of DHMP's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at DHMP's expected morbidity level. The difference between the market average risk pool and DHMP's expected morbidity is our estimate of what the risk adjustment transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected statewide risk scores (to estimate DHMP's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using MARA. We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

Project DHMP's Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected DHMP's risk scores (to estimate DHMP's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between DHMP and the overall Colorado market. Selection refers to the health status difference between a given carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

In the CMS risk adjuster transfer formula, the average premium in the state is the basis for calculating transfer payments. We estimated statewide claim costs (to estimate the statewide premium in DHMP's risk adjustment transfer payment) by applying steps 1-6 above to estimate the per member per month (PMPM) claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. DHMP is not selling platinum or bronze products, but we did assume some percentage of take-up of those plans in the marketplace as a whole.

Estimate DHMP's Risk Adjustment Transfer Payment

We estimated DHMP's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, DHMP's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether DHMP receives or makes a transfer payment is how DHMP's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding DHMP's expenses to the statewide average claim costs described above. Next, we normalized DHMP's risk score to the statewide average risk score and removed the portion of DHMP's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received by DHMP.

STEP 8: ESTIMATE IMPACT OF TRANSITIONAL REINSURANCE

We estimated additional costs due to the Federal transitional reinsurance program. We assumed an assessment of $5.25 PMPM in reinsurance contributions. We then assumed that DHMP will recover 80% of all individual members' per member per year (PMPY) incurred claims between $60,000 and $250,000. We estimated this value by calibrating the claims probability distributions (CPDs) from the HCGs for each of DHMP's individual benefit plans' estimated claims PMPMs.

STEP 9: CALCULATE INDEX RATE AND PLAN-SPECIFIC ADJUSTMENTS

After estimating claim costs for both products (steps 1-6) and expected receipts under the risk adjuster program (step 7) and transitional reinsurance program (step 8), we applied the retention loads discussed in Section H of this memorandum. This results in an aggregate PMPM required premium. We then project the average of all allowable rating factors (age and plan type). The ratio of required premium to average allowable rating factor is the index rate, as shown in Table 2. Further detail on these line items can be found following Table 2.

Table 2 – Development of required premium	
A. Expected claims, net of risk adjuster	$255.94
B. Transitional reinsurance expense, net of recoveries	-$25.85
C. Other administrative expenses	$51.85
D. Provision for profit and contingencies	$8.72
E. Total required premium (= A + B + C + D)	$290.65
F. Average of allowable rating factors (age, plan type)	1.3516
G. Index rate (= E/F)	**$215.05**

A more detailed breakdown of the expected claim amounts can be found in Table 3:

Table 3 – Detailed claim cost, risk adjuster, and reinsurance estimates (PMPM)					
Item	**Elevate (G) - Basic**	**Elevate (S) - Basic**	**Elevate (G) - Expanded**	**Elevate (S) - Expanded**	**Composite**
Projected member distribution	0.9%	29.1%	2.1%	67.9%	**100.0%**
Paid claims, net of risk adjuster receipts/payments	$352.51	$285.76	$300.33	$240.49	**$255.94**
Expected net transitional reinsurance recoveries	-$36.06	-$31.16	-$27.45	-$23.40	**-$25.85**
Total expected claims	**$316.45**	**$254.60**	**$272.88**	**$217.10**	**$230.09**

In Table 3, note that risk adjustment and reinsurance payments/receipts have been allocated to each plan only for display purposes. Due to the single risk pool requirements (45 CFR §156.80), the aggregate amounts for all individual products (in the right-most column) are used to calculate the market-wide index rate.

The amounts for administrative expenses and provision for profit and contingencies shown in Table 2 ($51.85 and $8.72) are the result of applying the retention percentages shown in Section H above.

The average allowable rating factor (1.3516) shown in Table 2 is the result of the following formula:

$$\overline{\text{ARF}} = \frac{\sum_{i=1}^{n}[\text{age}_i * \text{plan}_i]}{n}$$

Where:

$$\overline{\text{ARF}} = \text{Average allowable rating factor}$$

$$\text{age}_i = \text{Age factor for person i}$$

$$\text{plan}_i = \text{Plan type factor for person i}$$

$$\text{n} = \text{Total projected enrollment}$$

The age factors are shown in Addendum A, and are the ones required by the federal regulations. The plan factors are 1.0000 for the Elevate (S) – Basic plan,1.1532 for the Elevate (G) – Basic plan, 1.1604 for the Elevate (S) – Expanded plan and 1.3254 for the Elevate (G) – Expanded plan. We selected Elevate (S) – Basic as the reference point (1.0000) and calculated all other plans relative to this plan. The 1.1532 factor for Elevate (G) – Basic is entirely due to differences in actuarial value and cost sharing structure compared to the reference plan. For the two "Expanded" plans, differences compared to the reference plan are due to actuarial value and cost sharing and provider network. There are no differences between the plans attributable to the factors listed in 45 CFR §156.80(d)(2)(iii-v).

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan. (Under the single risk pool requirements of 45 CFR §156.80, differences in health status may not be used to make plan-level adjustments to the market-wide index rate.)

L. Trend

This section is labeled Section J in the May 7 guidance.

The historical experience data required by Regulation 4-2-11, Section 6L, are not available for this filing because these are new products.

As described in Section K above, the rates for these products were developed based on the 2012 HCGs. In order to produce claim costs on a 2014 basis, it was necessary to trend the claim cost projections by two years. The following medical trend assumptions were used:

Table 4 – Annual Trend assumptions

Component	Utilization Trend (Annual)	Unit Cost Trend (Annual)	Total (Annual)
Inpatient facility	0.0%	7.0%	7.0%
Outpatient facility	2.0%	7.5%	9.7%
Professional	1.5%	6.0%	7.6%
Prescription drugs	2.3%	5.8%	8.1%
Other	1.5%	6.0%	7.6%
All Benefits			**8.1%**

These trend rates represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. These are medical trend rates; of the sources of insurance trend listed in Regulation 4-2-11, Section L5(b), only deductible leveraging is relevant for these products. Rather than apply an adjustment to the medical trend rates to account for deductible leveraging, the impact of the deductible on paid claims is directly modeled by using allowed claim levels (trended to 2014 at the rates in Table 4) in claim probability distributions also trended to 2014 levels.

M. Credibility Considerations

This section is labeled Section K in the May 7 guidance.

This rate filing relies on data underlying the HCGs, as discussed above in Section K. The data include more than 2,000 life-years, and are therefore fully credible under Colorado Regulation 4-2-11, Section 6M.

N. Data Requirements

This section is labeled Section L in the May 7 guidance.

These are new products, and DHMP has never before sold individual insurance policies. DHMP's existing lines of business (Medicaid, CHP, Medicare, large group commercial) are significantly different from these products such that the experience is not applicable. These rates have been developed using experience underlying the HCGs, as discussed in Section K above, and consistent with guidance in Actuarial Standard of Practice No. 8 regarding health rate filings for new plans or benefits.

O. Side-by-Side Comparisons

This section is labeled Section M in the May 7 guidance.

A side-by-side comparison of current and proposed rates is not applicable, because this is an initial rate filing for new products.

Section Q below contains a list of all rating factors used. The plan design factors were developed according to the requirements of 45 CFR §156.80(d)(2). There are two types of plan level variations that are applicable to these plans. The impact of actuarial value and cost sharing was measured by using the HCGs to estimate the paid-to-allowed ratio and allowed claim costs for a population with standard demographics in both plan designs. By using a standard population (rather than the demographics of the projected DHMP population), we ensure that selection and health status do not affect the calculation of this factor. The impact of provider network differences between the "Basic" and "Expanded" plan designs was measured using the HCGs to estimate the allowed cost under each plan design for a population with standard demographics (again, to ensure that health status differences do not affect the plan factors).

DHMP has elected not to employ a tobacco factor.

DHMP's products are only sold in one of the state's rating areas, so there are no area factors.

The age factors shown in Addendum A are mandated by federal regulation (see 45 CFR §147.102).

P. Benefits Ratio Projections

This section is labeled Section N in the May 7 guidance.

The following table shows projected premium, claims, and benefits ratio for 2014. Because this is a new product, the requirement in Regulation 4-2-11 to provide this information without the rate filing is not applicable. Note that the values in this table are based on the definition of "benefits ratio" in Regulation 4-2-11. The federal MLR definition is different.

Table 5 – Benefits ratio projection	
Component	**Value**
Projected premium, PMPM	$290.65
Projected claims, net of risk adjustment receipts, PMPM	$255.94
Projected benefits ratio	88.06%

Q. Other Factors Used

This section is labeled Section O in the May 7 guidance.

The following table contains a summary of the rating factors used for these products. These are all multiplicative adjustments to the market-wide index rate of $215.05

When family coverage is purchased, each family member will be rated separately, and the sum of the individual premiums will equal the family premium, with the constraint that no more than three members under the age of 21 will contribute to the family premium.

Rating areas are those released by the Division of Insurance on March 27, 2013. Consistent with its DOI-approved service area, DHMP will sell these products only in certain counties within Rating Area 3.

Table 6 – Rating factors	
Factor	**Value**
Elevate (G) - Basic	1.1532
Elevate (S) - Basic	1.0000
Elevate (G) - Expanded	1.3254
Elevate (S) - Expanded	1.1604
Tobacco surcharge	1.0000
Rating Area 1 (plans not available in this area)	N/A
Rating Area 2 (plans not available in this area)	N/A
Rating Area 3 (plans offered only in Denver, Adams, Arapahoe, and Jefferson Counties)	1.0000
Rating Area 4 (plans not available in this area)	N/A
Rating Area 5 (plans not available in this area)	N/A
Rating Area 6 (plans not available in this area)	N/A
Rating Area 7 (plans not available in this area)	N/A
Rating Area 8 (plans not available in this area)	N/A
Rating Area 9 (plans not available in this area)	N/A
Rating Area 10 (plans not available in this area)	N/A
Rating Area 11 (plans not available in this area)	N/A
Age	See Addendum A

R. Rating Manuals and Underwriting Guidelines

There are underwriting guidelines applicable to these products. Section K provides a complete description of how rates are developed and how they vary from one applicant to another. The “rate manual” is attached in SERFF, and contains the same information shown in Section Q above.

Mary van der Heijde, FSA, MAAA
Member, American Academy of Actuaries
May 10, 2013

Milliman
1400 Wewatta Street, Suite 300
Denver, CO 80202
(303) 672-9081

Addendum A

AGE FACTORS

Under 45 CFR §147.102, all carriers in each state must use a standardized set of age factors. There is a federal default which is to be used in states (such as Colorado) that do not set their own factors. The following are the age factors that will be used as multiplicative adjustments to the market-wide index rate.

Table A.1 – Age Factors

Age	Factor	Age	Factor
0-20	0.635	43	1.357
21	1.000	44	1.397
22	1.000	45	1.444
23	1.000	46	1.500
24	1.000	47	1.563
25	1.004	48	1.635
26	1.024	49	1.706
27	1.048	50	1.786
28	1.087	51	1.865
29	1.119	52	1.952
30	1.135	53	2.040
31	1.159	54	2.135
32	1.183	55	2.230
33	1.198	56	2.333
34	1.214	57	2.437
35	1.222	58	2.548
36	1.230	59	2.603
37	1.238	60	2.714
38	1.246	61	2.810
39	1.262	62	2.873
40	1.278	63	2.952
41	1.302	64+	3.000
42	1.325		

Plan Name	Metal Tier	Rating Area	Network	Premium
Elevate (G) - Expanded	Gold	Rating Area 3	CON002	364.25
Elevate (S) - Expanded	Silver	Rating Area 3	CON002	318.91
Elevate (G) - Basic	Gold	Rating Area 3	CON001	316.95
Elevate (S) - Basic	Silver	Rating Area 3	CON001	274.83

DHMP response to Objection 8:

Below is a tabular version of the data entered on the “requested rate” section in SERFF.

Benefits ratio projection	
Component	**Value**
Projected earned premium	$27,543,060
Projected incurred claims	$28,183,056
Projected benefits ratio	**102.32%**

Note that the rate review detail for projected incurred claims does not include risk adjuster receipts, while the benefit ratio calculation in the actuarial memorandum, section P, does incorporate risk adjuster receipts as an offset to claims. This is the reason that the 102.32% ratio in the table above is not the same as the original table in Section P of the memorandum.

DHMP response to Objection 6:

We have implemented each of these PPACA benefit changes:

Table 1 – List of PPACA Benefits	
PPACA Benefit	**Implemented for 2014?**
Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA	**Yes**
Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA	**Yes**
Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA	**Yes**
Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA	**Yes**
Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA	**Yes**
Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA	**Yes**
Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA	**Yes**
Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA	**Yes**
Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA	**Yes**
Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA	**Yes**

ACTUARIAL MEMORANDUM

Pursuant to Colorado Regulation 4-2-11 Section 6, rate filings must contain an Actuarial Memorandum. The Division of Insurance developed this template Memorandum and table General filing requirements, Actuarial Certification requirements, and submission requirements are identified in Section 5 of Colorado Regulation 4-2-11. For without ALL requirements of the regulations could be disapproved or rejected by the Colorado Division of Insurance.

Company:	**Denver Health Medical Plan**
NAIC #:	**95750**
SERFF Filing #:	**DVHH-129023224**
SERFF Binder Filing #:	**DVHH-CO14-125001113**

A: SUMMARY	
1. Reason(s):	This rate filing is for new products to be sold on the Colorado Health Benefit Exchange (COHBE) starting Jan
2. Requested Rate Action:	This filing contains the initial rates for this product; because the products are new, this is neither a rate increa
3. Marketing method(s):	These products will be marketed using television, radio, out-of-home, and print media, as well as through gra
4. Premium Classification(s):	Under the Patient Protection and Affordable Care Act (PL 111-148 and PL 111-152; hereafter, "ACA"), premiums for the same product may vary among individuals only based on age, tobacco use, family composition, and geographic area (Public Health Service Act, §2701, as amended by the ACA, §1201). The premiums for each product will vary only based on member age. DHMP has chosen not to vary rates based on tobacco use, and rates do not vary based on geographic area because DHMP's service area is entirely contained within the Denver rating area (as defined in guidance issued by the Colorado Division of Insurance on March 27, 2013). Federal regulation clarified that for family composition, each family member must be rated as an individual, but no more than three family members under age 21 may be taken into account when calculating the premium for family coverage (45 CFR §147.102(c)). Accordingly, premiums for these products will vary by age, and each individual family member will be rated separately, except that for families with more than three children under age 21, only the first three will be counted.

5. Product Description(s):	**This rate filing covers two products, comprising four plan designs. Each product has two metal level plan designs:** **§ DHMP will offer two plans with a silver level of coverage, as defined by the ACA, §1302(d): Elevate (S) – Basic and Elevate (S) - Expanded. The cost sharing structure and levels are identical; the only difference is the scope of the provider network. There are several variants of the benefit design for these products, which will be sold to individuals who qualify for each variant. In particular, there are cost sharing reduction (CSR) variants at the 94%, 87%, and 73% actuarial value levels, which will be sold to those who qualify, according to 45 CFR §156.420(a). Also, there are two variants of each available to qualifying Native Americans, as required by 45 CFR §156.420(b): one with no cost sharing (100% actuarial value), and a second with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).** **§ DHMP will offer two plans with a gold level of coverage, as defined by the ACA, §1302(d): Elevate (G) – Basic and Elevate (G) – Expanded. The cost sharing structure and levels are identical; the only difference is the scope of the provider network. Also, there are variants available to qualifying Native Americans, as required by 45 CFR §156.420(b), with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603). Guidance published in the Federal Register, Vol. 78, No. 47, p. 15494 (March 11, 2013) states that in non-FFE states, when a set of plan designs differ only in cost sharing and premium (as is the case for DHMP's products), a zero-cost variant for qualifying Native Americans must only be offered for the lowest-cost plan. Thus, under federal rules, a zero-cost variant is not required for the Gold product. Nonetheless, the Plan & Benefits Template, which must be submitted with this rate filing, automatically creates a zero-cost variant for all plans. It is not DHMP's intent to offer the zero-cost variant at the Gold level unless the DOI or COHBE should require it, since the benefits would be identical to those of the Silver plan but the premium would be higher.**
6. Policy/Rider Impacted:	A list of all policy forms affected by this rate filing can be found on the forms schedule tab in SERFF.
7. Age Basis:	Premiums are charged on an attained-age basis, based on age at the date of policy issuance or renewal. Sec
8. Renewability provision:	This policy is guaranteed renewable. Premiums are not guaranteed for any period after December 31, 2014.
Additional Information:	

B. ASSUMPTION, MERGER OR ACQUISITION	
1. Is product part of assumption, acquisition, or merger (from or with another company)?	**No**
Assumption:	**No**
Acquisition:	**No**
Merger:	**No**
2. If yes, provide name of company(s):	
3. Closing Date of assumption, merger or acquisition:	
Additional Information:	

C. RATING PERIOD	
Proposed Effective Date: (may not say "upon approval")	**1/1/14**
Rating Period:	**Annual**
Rating Period Dates:	**1/1/2014 to 12/31/2014**

D. EFFECT OF LAW CHANGES	

Identify and quantify changes resulting from mandated benefits and other law changes:	**These are new products and have been designed to conform to all legal and regulatory requirements (federal and state) as of the date of this filing. Because the products are new, there are no prior rates against which changes can be measured. This filing does not account for any laws that may be signed after the date of this memorandum, nor any regulatory changes that may be issued after the date of this memorandum.**
Additional Information:	

E. RATE HISTORY	
Provide rate changes made in at least the last three years (If available) **N/A (Initial Filing)**	**Complete tab "Rate History"**

F: COORDINATION OF BENEFITS	
Provides actual loss experience net of any savings:	These are new products, so there is no rate history available. The Rates Template, uploaded elsewhere in SERFF, contains the proposed 2014 rates for each combination of plan design and age.
Additional Information:	

G. RELATIONSHIP OF BENEFITS TO PREMIUM	
Description	**Percentage**
Commissions	0.00%
General expenses	15.48%
Premium taxes	0.00%
Profit/Contingencies	3.00%
PPACA Fees	0.39%
Exchange Fees	1.40%
Investment Income	0.00%
Other	-8.33%
Total Retention:	11.94%
Targeted Loss Ratio:	88.06%

H. PROVISION FOR PROFIT AND CONTINGENCIES	
1. Provision for Profit and Contingencies:	**3%**
2. Proposed load in excess of 7% after tax.	**0**
Provide detailed support:	
Additional Information:	

I. DETERMINATION OF PROPOSED RATES
Include all underlying rating assumptions, with detailed support for each assumption. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis. (this can be attached with support in a pdf document)

1. Explain, in detail, how rates and/or rate changes were developed:	**Background** **Under federal rules implementing the ACA (published in the Federal Register February 27, 2013, Vol. 78, No. 39, pp. 13406-13442), insurance issuers in the individual market must follow a prescribed set of guidelines in setting premiums. The basic approach is to develop a "market-wide index rate," which is applicable to all plans if the issuer sells in the individual market. To that index rate, multiplicative adjustment factors are applied to calculate an individual member's premium. Those adjustment factors are:** **Plan selection factor (due to actuarial value and cost sharing design, provider network, delivery system, and utilization management practices, benefits in addition to EHBs, administrative costs, and characteristics of catastrophic plans)** **Age factor** **Geographic area factor** **Tobacco use factor** **For the products in this rate filing, only the index rate, plan selection factors, and age factors are relevant, because DHMP only operates in a single geographic area of the state and has elected not to use a tobacco factor.** **This section of the memorandum describes the process we followed to develop the index rate for DHMP's individual products and the plan-specific adjustment factors.** **In this context, an An index rate is not the average claim cost or average premium for the projected insured population. Rather, the index rate is a base rate to which the factors above are applied to arrive at a premium for an individual member. It would not be mathematically possible for the index rate to represent a market average premium or claim cost for the entire insured population, because the set of age factors required by law does not have a 1.00 average (when weighted across the age profile of the insured population). The projected average claim costs and premium for this population can be found in Table 2 below, but the index rate is something different from either of these (as shown in the last row of Table 2).** **Data** **Because DHMP has no prior individual product claim experience, there is no actual DHMP claim experience available for these products. The Milliman Health Cost Guidelines™ (HCG) cost and utilization**
2. Provide adequate support for all assumptions and methodologies used:	**See cell C73, or the memorandum to which this file is attached.**

J. TREND	
Additional support and information must be provided on the "Historical Trend" and "Normalized Trend" tabs	
Itemized trend component	**Trend (%)**
MEDICAL TREND (total)	
Medical provider price increase	
Utilization changes	
Medical cost shifting	
Medical procedures and new technology	
INSURANCE TREND (total)	
Underwriting wearoff	
Deductible leveraging	
Anti-selection	
PHARMACEUTICAL TREND (total)	
Price increases	

Utilization changes	
Cost shifting	
Introduction of new brand and generic drugs	
TOTAL AVERAGE ANNUALIZED TREND (required)	**8.10%**
Additional information:	**The memorandum provides additional detail by service category.**

K. CREDIBILITY	
1. Credibility Percentage (Colorado Only):	**% If other, please specify**
The above credibility percentage is based upon:	**Life Years Claims**
Other (please specify)	
2. Number of years of data used to calculate above credibility percentage:	
3. Discuss how and if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.	
Additional Information: (including collateral data, if used)	**Please see the memorandum.**

L. DATA REQUIREMENTS	**Complete tab "Data Requirements"**

M. SIDE-BY-SIDE COMPARISON	**Complete tab "Side by Side Comparison"**

N. BENEFITS RATIO PROJECTIONS	**Complete tab "Projected Benefits Ratio"**

O. OTHER FACTORS	
Identify and provide support for other rating factors and definitions, including area factors, age factors, gender factors, etc.:	**A side-by-side comparison of current and proposed rates is not applicable, because this is an initial rate filing for new products. Section Q below contains a list of all rating factors used. The plan design factors were developed according to the requirements of 45 CFR §156.80(d)(2). There are two types of plan level variations that are applicable to these plans. The impact of actuarial value and cost sharing was measured by using the HCGs to estimate the paid-to-allowed ratio and allowed claim costs for a population with standard demographics in both plan designs. By using a standard population (rather than the demographics of the**
Additional Information:	

Instructions/Descriptions
Company Name
NAIC Company Code (CoCode)
SERFF Filing Number

A statement whether this is a new filing, a rate revision, or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be stated.
The overall rate increase or decrease amount should be listed. List rate change and average change in each component of rate changes and renewal by effective months. List 12 month renewal with changes by component and the averages by component.
A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other)
The section should state all attributes upon which the premium rates vary. This must comply with the new rating reforms.

This section should describe the benefits provided by the policy. ▪Must include EHB and list any substitution of benefits or any additional benefits above the EHB.
This can be completed on the form schedule tab in SERFF
A statement as to whether the premiums will be charged on an issue age, attained age, renewal age or other basis and the issue age range of the form should be specified.
All policies should be guaranteed renewable.

Yes/No
Yes/No
Yes/No
Yes/No
Company Name
DD/MM/YYYY

The memorandum must identify the period for which the rates will be effective.
Date (DD/MM/YYYY)
(Annual, Semi-Annual, Quarterly, Other)
DD/MM/YYYY to DD/MM/YYYY

The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in law(s) or regulation(s), including federal, state or local. All applicable benefit mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

Each rate filing must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

(This number should equal 1 minus the total retention percentage listed above.)

The memorandum must identify the percentage of the provision for profit and contingencies, and how this provision is included in the final rate. If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load.

The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. This includes all rating factors.

Describe the trend assumptions used in pricing. Each assumption must be separately discussed, adequately supported, and must also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. The Total Average Annualized Trend MUST be filled out. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.

The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience. Discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Identify and discuss the source, applicability and use of collateral data used to support partially credible Colorado data. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT{(#life years or claims)/full credibility standard}. The full credibility standard is defined above

The memorandum must clearly display or clearly reference all other rating factors and definitions, including the area factors, age factors, gender factors, etc., and support for each of these factors in a new rate filing. The same level of support for changes to any of these factors must be included in renewal rate filings. In addition, the Commissioner expects each carrier to review each of these rating factors at least every five years and provide detailed support for the continued use of each of these factors in a rate filing. Gender factors shall not vary for individual health care coverage effective on or after January 1, 2011. See Section 8.C of this regulation.

E. RATE HISTORY					
Provide rate changes made in at least the last three years (If available) **N/A (Initial Filing)**					
COLORADO					
State Tracking Number		**% OF CHANGE**			
or SERFF Tracking Number	**Effective Date**	**Minimum**	**Average**	**Maximum**	**Cumulative for past 12 Months**
N/A (Initial filing)					

NATIONWIDE		
Effective Date	**Average % of change**	**Cumulative for past 12 Months**
Additional Information:		

L. DATA REQUIREMENTS

Colorado-only basis for at least 3 years. **Include** national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period must include consecutive data no older than 9 months prior to the proposed effective date.

COLORADO

Year*	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Total Estimated IBNR Claims	Loss Ratio	Average Covered Lives	Number of Claims	Colorado On Rate Level Premium
2010								
2011								
2012								
2013								

*This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY		
Above data is for:	N/A Existing Product Comparable Product Other _____(please specify)	

OTHER DATA

Year	Earned Premium	Incurred Claims	Total Estimated Incurred Claims	Total Estimated IBNR Claims	Average Covered Lives	Number of Claims
2010						
2011						
2012						
2013						

Above data is for:	N/A Existing Product Comparable Product National Other (please specify)	
Experience Period: (From____ to_____)		
Additional Information:	This is an initial filing for a carrier without prior experience in this market. Please see the memorandum for a detailed discussion of data used.	

M. SIDE-BY-SIDE COMPARISON	N/A		
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.			
Description	**Current Rate/ Rating Factor/ Rating Variable**	**Proposed Rate/ Rating Factor/Rating Variable**	**Percentage Increase/ Decrease**
If the above table is not used, please identify the location of the Side by-Side Comparison in the rate filing:	**See Sections O and Q in memorandum.**		
Description and detailed support for new rating factor(s):			
Additional Information:			

N. PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	Incurred Claims	Benefits Ratio
Projected Experience Without Rate Change	N/A	N/A	N/A
Projected Experience With Rate Change	290.65	255.94	88.06%
Additional Information	Premiums and incurred claims are stated on a PMPM basis.		

In this Model the health plan will only be asked to enter data shown in Red, the other cells are all calculated as part of the State's Evaluation Model

Step 1:
Enter Your Member and Claim Information for the most Recent 4 Years. If your plan has less than 4 years of data then enter the amount since plan inception.
The most recent month should be within 6 months of the date that you filed rates. Enter the most recent month in Row# 48.

Month Through Which Claims are Paid: Mar-12

			Medical		Pharmacy		Medical	Pharmacy	Total
			Total	Estimated	Total	Estimated	12-Month	12-Month	12-Month
Row #	Month	Members	Incurred Claims	IBNR Claims	Incurred Claims	IBNR Claims	pmpm Trend	pmpm Trend	pmpm Trend
1	Jan-08								
2	Feb-08								
3	Mar-08								
4	Apr-08								
5	May-08								
6	Jun-08								
7	Jul-08								
8	Aug-08								
9	Sep-08								
10	Oct-08								
11	Nov-08								
12	Dec-08								
13	Jan-09								
14	Feb-09								
15	Mar-09								
16	Apr-09								
17	May-09								
18	Jun-09								
19	Jul-09								
20	Aug-09								
21	Sep-09								
22	Oct-09								
23	Nov-09								
24	Dec-09								
25	Jan-10								
26	Feb-10								
27	Mar-10								
28	Apr-10								
29	May-10								
30	Jun-10								
31	Jul-10								
32	Aug-10								
33	Sep-10								
34	Oct-10								
35	Nov-10								
36	Dec-10								
37	Jan-11								
38	Feb-11								
39	Mar-11								
40	Apr-11								
41	May-11								
42	Jun-11								
43	Jul-11								
44	Aug-11								
45	Sep-11								
46	Oct-11								
47	Nov-11								
48	Dec-11								

			Medical		Pharmacy		One Year Trends		
Start	End	Members	Total	Estimated	Total	Estimated	Medical	Pharmacy	Total
Month	Month	Months	Incurred Claims	IBNR Claims	Incurred Claims	IBNR Claims	Trend	Trend	Trend
Jan-08	Dec-08	0	0	0	0	0			
Jan-09	Dec-09	0	0	0	0	0			
Jan-10	Dec-10	0	0	0	0	0			
Jan-11	Dec-11	0	0	0	0	0			

In this Model the health plan will only be asked to enter data shown in Red, the other cells are all calculated as part of the State's Evaluation Model

Enter Your Member and Normalized Claim Information for the most Recent 4 Years. If your plan has less than 4 years of data then enter the amount since plan inception.
The most recent month should be within 6 months of the date that you filed rates. Enter the most recent month in Row# 48.
Claims should be normalized for demographic changes, benefit changes, uw wear-off if applicable, and any other rating factors that are appropriate to normalize for.

Month Through Which Claims are Paid: Mar-12

			Medical Normalized	Pharmacy Normalized	Medical 12-Month	Pharmacy 12-Month	Total 12-Month
Row #	Month	Members	Incurred Claims	Incurred Claims	pmpm Trend	pmpm Trend	pmpm Trend
1	Jan-08						
2	Feb-08						
3	Mar-08						
4	Apr-08						
5	May-08						
6	Jun-08						
7	Jul-08						
8	Aug-08						
9	Sep-08						
10	Oct-08						
11	Nov-08						
12	Dec-08						
13	Jan-09						
14	Feb-09						
15	Mar-09						
16	Apr-09						
17	May-09						
18	Jun-09						
19	Jul-09						
20	Aug-09						
21	Sep-09						
22	Oct-09						
23	Nov-09						
24	Dec-09						
25	Jan-10						
26	Feb-10						
27	Mar-10						
28	Apr-10						
29	May-10						
30	Jun-10						
31	Jul-10						
32	Aug-10						
33	Sep-10						
34	Oct-10						
35	Nov-10						
36	Dec-10						
37	Jan-11						
38	Feb-11						
39	Mar-11						
40	Apr-11						
41	May-11						
42	Jun-11						
43	Jul-11						
44	Aug-11						
45	Sep-11						
46	Oct-11						
47	Nov-11						
48	Dec-11						

			Medical	Pharmacy	One Year Trends		
Start Month	End Month	Members Months	Total Incurred Claims	Total Incurred Claims	Medical Trend	Pharmacy Trend	Total Trend
Jan-08	Dec-08	0	0	0			
Jan-09	Dec-09	0	0	0			
Jan-10	Dec-10	0	0	0			
Jan-11	Dec-11	0	0	0			

Objection 2 (5/29/2013):

Comments:
When a Colorado Actuarial Memorandum is attached, please provide: Regulation 4-2-11 section 6 (A)-PPACA rate filing procedure section (A) 5, Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB.

DHMP response to Objection 2:

This information can be found in Section A of the actuarial memorandum. The relevant portion is reproduced below (emphasis added where EHBs are discussed). To clarify, there are no EHB substitutions.

Excerpt from Actuarial Memorandum

This rate filing covers two products, comprising four plan designs. Each product has two metal level plan designs:

DHMP will offer two plans with a silver level of coverage, as defined by the ACA, §1302(d): Elevate (S) – Basic and Elevate (S) - Expanded. The cost sharing structure and levels are identical; the only difference is the scope of the provider network. There are several variants of the benefit design for these products, which will be sold to individuals who qualify for each variant. In particular, there are cost sharing reduction (CSR) variants at the 94%, 87%, and 73% actuarial value levels, which will be sold to those who qualify, according to 45 CFR §156.420(a). Also, there are two variants of each available to qualifying Native Americans, as required by 45 CFR §156.420(b): one with no cost sharing (100% actuarial value), and a second with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603).

DHMP will offer two plans with a gold level of coverage, as defined by the ACA, §1302(d): Elevate (G) – Basic and Elevate (G) – Expanded. The cost sharing structure and levels are identical; the only difference is the scope of the provider network. Also, there are variants available to qualifying Native Americans, as required by 45 CFR §156.420(b), with no cost sharing for essential health benefits furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in 25 USC 1603). Guidance published in the Federal Register, Vol. 78, No. 47, p. 15494 (March 11, 2013) states that in non-FFE states, when a set of plan designs differ only in cost sharing and premium (as is the case for DHMP's products), a zero-cost variant for qualifying Native Americans must only be offered for the lowest-cost plan. Thus, under federal rules, a zero-cost variant is not required for the Gold product. Nonetheless, the Plan & Benefits Template, which must be submitted with this rate filing, automatically creates a zero-cost variant for all plans. It is not DHMP's intent to offer the zero-cost variant at the Gold level unless the DOI or COHBE should require it, since the benefits would be identical to those of the Silver plan but the premium would be higher. The benefit designs are provided in other templates submitted with this rate filing.

Each of these plans provide the essential health benefits (EHB) described in the ACA, §1302. There are no supplemental (non-EHB) benefits. The federal government gave each state the flexibility to choose an EHB package based on one of ten possible benchmark options. Colorado has selected the largest small group plan in the state (Kaiser Foundation Health Plan of Colorado Deductible/Coinsurance HMO 1200D), supplemented by the pediatric dental benefits in the CHP+ program. Neither DHMP product includes a pediatric dental benefit due to the expected presence of a standalone dental plan on COHBE. Under the ACA, §1302(b)(4)(F), a QHP is not required to offer pediatric dental benefits if a stand-alone dental plan is available on the state exchange. The DOI has

established a filing deadline for stand-alone dental products that is later than the filing deadline for individual medical plans. Therefore, it cannot be known with certainty as of the filing date that a stand-alone dental plan will be available on COHBE. We would re-file new rates should it become necessary at a later date for DHMP to add pediatric dental benefits (if, for example, no stand-alone dental plan is filed, or none is approved by the DOI, or none is certified by COHBE). DHMP has no intention of offering a pediatric dental benefit in 2014 provided that a stand-alone option is available on COHBE.

Both products follow a closed-panel model, using providers of Denver Health and Hospital Authority (Denver Health) as the network. In the “expanded” products, University Hospital and Children’s Hospital are also included in the network, along with their affiliated physicians. Members are required to choose a network primary care physician (PCP). The plans cover services provided by non-network providers only when authorized by DHMP, and for urgent or emergency care. Prescription drug benefits are provided both at the Denver Health pharmacy and at participating network pharmacies, with cost sharing for members being significantly lower at the Denver Health pharmacy (and certain prescription drugs are only available at the Denver Health pharmacy).

Response to Objections to filing DVHH-129023224:

Denver Health Medical Plan, Inc.

Objection 1 (6/14/2013):

Comments:
Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.

DHMP response to Objection 1:

In the instructions for the URRT issued on April 29, 2013, the Index Rate is described as follows:

"As noted in Section I, the index rate represents the average allowed claims PMPM for essential health benefits. This legal entity-specific rate for the projection period should not reflect any adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply projected allowed claims PMPM for essential health benefits."

Based on this guidance, we set the Index Rate in the URRT to the Allowed Claims PMPM before reinsurance and risk adjustment. Note that the Index Rate provided in the URRT is not explicitly used in developing premiums. Factors for allowable rating characteristics including plan factors, age factors, area factors, and smoking factors were applied to a base rate of $215.05 to develop rates. To arrive at this, the total Projected Allowed Claims were converted to projected incurred claims by applying the average paid-to-allowed factor. Non-claims expenses were then applied to arrive at the average carrier premium. A plan factor for each projected member cohort was developed using a product of the ACA allowable rating characteristics. Note that this number is slightly different than the product of the average of each separate allowable rating characteristic. The average premium of $290.65 was divided by the membership-weighted average total rating factor of 1.352 to arrive at a base rate of $215.05, from which all premiums were determined.

Development of index rate	
Projected Allowed Claims Experience	$411.44
Times: Average Paid-to-Allowed Factor	0.723
Equals: Projected Incurred Claims	$297.41
Plus: Administrative Expenses	$51.85
Plus: Risk Adjuster Paid (Received)	-$41.47
Plus: Federal Reinsurance Paid (Received)	-$25.85
Plus: Target Profit	$8.72
Equals: Average Premium	$290.65
Average Area Factor:	1.000
Average Age Factor	1.283
Average Tobacco Factor	1.000
Average Plan Factor	1.053
Membership Weighted Average of Total Rating Factor	1.352
Average Premium	$290.65
Divided By: Weighted Average of Total Rating Factor	1.352
Equals: Base Rate Used in Pricing	$215.05

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/13/2013		Supporting Document	Rate Sample	06/03/2013	State of Colorado - Rate Sample.xlsx
05/10/2013		Form	DHMP ElevateG Basic EOC (80%)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Basic EOC (Zero Cost Sharing Native American)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Basic application (80%)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Basic SBC (80%)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Basic SBC (Zero Cost Sharing Native American)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Expanded EOC (80%)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Expanded EOC (Zero Cost Sharing Native American)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Expanded application (80%)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Expanded SBC (80%)	06/03/2013	
05/10/2013		Form	DHMP ElevateG Expanded SBC (Zero Cost Sharing Native American)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Expanded EOC (70%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Expanded EOC (73%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Expanded application (70%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Expanded SBC (70%)	06/03/2013	

SERFF Tracking #: DVHH-129023224 **State Tracking #:** 278033 **Company Tracking #:**

State: Colorado **Filing Company:** Denver Health Medical Plan, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Elevate by Denver Health Medical Plan, Inc.
Project Name/Number: /

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/10/2013		Form	DHMP ElevateS Expanded SBC (73%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Basic SBC (70%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Basic SBC (73%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Basic EOC (70%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Basic EOC (73%)	06/03/2013	
05/10/2013		Form	DHMP ElevateS Basic application (70%)	06/03/2013	
05/09/2013		Supporting Document	Actuarial Memorandum and Certifications	05/15/2013	DHMP Part III memorandum 5-10-2013.pdf Actuarial Memorandum (DOI Excel template).xlsx Actuarial memorandum - DHMP individual products 5-10-2013.pdf